

VETERANS' ADMINISTRATION HEALTH-CARE AMENDMENTS OF 1987

JUNE 26, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MONTGOMERY, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

[To accompany H.R. 2616]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 2616) to amend title 38, United States Code, to improve health-care programs of the Veterans' Administration, having considered the same, reports favorably thereon with an amendment, by unanimous voice vote, and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follow:

Page 2, strike out lines 8 through 14 and insert in lieu thereof the following:

(a) CERTAIN VETERANS WITH SERVICE-CONNECTED DISABILITIES.—Section 612(a) is amended by striking out "may furnish" and inserting in lieu thereof "shall furnish".

(b) OTHER VETERANS.—Paragraph (1) of section 612(f) is amended to read as follows:

"(f)(1)(A) In addition to the medical services provided under subsection (a) of this section, the Administrator shall furnish medical services on an outpatient or ambulatory basis—

"(i) to any veteran who is a former prisoner of war, for any disability; and

"(ii) to any other veteran eligible for hospital care under section 610(a)(1) of this title, for any purpose described in subparagraph (C) of this paragraph.

"(B) Subject to paragraph (4) of this subsection, the Administrator may furnish medical services on an outpatient or ambulatory basis to a veteran eligible for hospital care under section 610 of this title (other than under section 610(a)(1)) for any purpose described in subparagraph (C) of this paragraph.

"(C) Medical services described in this subparagraph are medical services reasonably necessary—

"(i) in preparation for hospital admission;

"(ii) to obviate the need of hospital admission, but in the case of a veteran described in subparagraph (B) of this paragraph, only to the extent that facilities are available; and

"(iii) in the case of a veteran who has been furnished hospital care, nursing home care, or domiciliary care, to complete treatment incident to such care, but only for a period not in excess of 12 months after discharge from such care, unless the Administrator finds that a longer period is required by reason of the disability being treated."

(c) CONFORMING AMENDMENT.—Section 603(a)(2)(B) is amended by striking out "section 612(f)(1)(A)(ii)" and inserting in lieu thereof "section 612(f)(1)(C)(iii)".

Page 16, line 16, strike out "The appointment" and all that follows through the period on line 20.

Page 16, beginning on line 24, strike out "by reason of abolishment of position."

Page 20, line 5, insert "(a)" before "Notwithstanding".

Page 20, line 13, strike out the quotation marks and the second period.

Page 20, after line 13, insert the following:

"(b) For purposes of this subsection, the term 'settle', with respect to a claim, means consider, ascertain, adjust, determine, and dispose of the claim, whether by full or partial allowance or by disallowance."

Page 21, strike out lines 13 through 18.

Page 22, line 10, strike out "(a) RESTORAL.—Section 113(b)(2)" and insert in lieu thereof "(a) RESTORATION.—Section 113(b)(2)(B)".

Page 24, after line 10, insert the following new section:

SEC. 308. NAME OF MEDICAL CENTER, SHREVEPORT, LOUISIANA.

The Veterans' Administration Medical Center in Shreveport, Louisiana, shall after the date of the enactment of this Act be known and designated as the "Overton Brooks Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Overton Brooks Veterans' Administration Medical Center.

INTRODUCTION

The Subcommittee on Hospitals and Health Care held a hearing on April 22, 1987 on, among other subjects, the status of recruitment and retention of Veterans' Administration health care personnel. Testimony was received from the Nurses Organization of the Veterans' Administration, the National Association of VA Physicians, the Veterans' Administration, The American Legion, Disabled American Veterans, Veterans of Foreign Wars, Paralyzed Veterans of America, and AMVETS.

The Subcommittee also held a hearing on May 20, 1987 on legislation concerning the Veterans' Administration health care delivery programs. Testimony was received on draft legislation to assist the Veterans' Administration in recruitment and retention of health care personnel, especially nurses and pharmacists, as well as a pilot program on hospital management efficiency, changes in eligibility for outpatient care, domiciliary care and nursing home care, and providing care for homeless veterans with chronic psychiatric disabilities. The Subcommittee also received testimony on H.R. 2002, H.R. 2003, H.R. 2004, H.R. 2006, H.R. 2007, H.R. 2146 and H.R. 2327. Testimony was provided by the Honorable Gerald B. H. Solomon, the Honorable Sherwood L. Boehlert, the Disabled American Veterans, the Veterans of Foreign Wars, Paralyzed Veterans of America, Inc., Vietnam Veterans of America, The American Legion, and the Veterans' Administration.

On June 3, 1987, the Subcommittee unanimously recommended draft legislation incorporating all the legislation considered by the Subcommittee on May 20, 1987. On June 4, 1987, the draft legislation was introduced and designated as H.R. 2616. The full Commit-

tee met on June 10, 1987 and ordered H.R. 2616, as amended, reported by the House by unanimous voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 2616, as amended would:

Require the Veterans Administration to provide outpatient care for service-connected disabled veterans for their service-connected disabilities and for all medical conditions of veterans rated 50% or more disabled as well as former prisoners of war (POWs). Other Category A veterans would be provided entitlement for outpatient care in preparation for, to obviate the need for, and as a follow-up to, hospital care. (Definition of Category A: Veterans with service-connected disabilities; former POWs; veterans exposed to certain herbicides and ionizing radiation; veterans disabled as a result of VA treatment or vocational rehabilitation; veterans of the Spanish-American war, Mexican border period, or World War I; and non-service-connected veterans with one dependent whose income does not exceed \$18,234 [or \$15,195 for a single veteran].) Note: Category B and C veterans' outpatient eligibility is not changed.

Clarify and correct a disparity between service-connected and non-service-connected veterans with respect to domiciliary care eligibility requirements.

Update Veterans' Administration definition of nursing home care to reflect modern distinctions of skilled, intermediate and combined nursing home care.

Clarify Veterans' Administration authority to furnish veterans receiving VA care with therapeutic recreational activities outside the confines of a VA facility.

Provide the Administrator of Veterans' Affairs with authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense.

Provide entitlement for outpatient medical services for persons disabled by Veterans' Administration treatment or vocational rehabilitation.

Prevent transfer of "storefront" Vet Centers into Veterans' Administration medical facilities before a 120-day period after Congressional receipt of two reports from the Veterans' Administration which are required by law.

Extend the contract adult day health care authority for three years, from September 30, 1988 to September 30, 1991.

Provide authority for fee-basis care for service-connected disabilities to Canadian citizens who served in the U.S. military forces and who now reside in Canada.

Repeal requirement for a Veterans' Administration annual report on contract care.

Require a pilot program to provide care and treatment and rehabilitative services (by contract or otherwise) in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are eligible for hospital care as Category A veterans.

Update title 38, United States Code, to reflect existing Federal pay rates. This provision would not provide any pay increase.

Provide authority for premium pay for duty on Saturday for nurses on the same basis current law provides for Sunday premium pay.

Permit the Administrator, in order to recruit and retain pharmacists, to set rates of pay and qualifications standards without regard to civil service law, rules and regulations.

Provide an explicit process for hearings for adverse medical personnel actions of removal, suspension for more than 14 days, or a demotion involving the loss of grade or pay.

Broaden eligibility for the Veterans' Administration's health professional scholarship program to include such medical personnel as physical therapists, laboratory technicians, respiratory therapists, and administrators.

Provide that temporary workers hired only for duties directly related to the conduct of research projects shall not be considered to be VA employees for purposes of any personnel ceilings which may otherwise be applied to VA employees by the President.

Allow flexibility to the Chief Medical Director to organize his personal office, provide for a removal system for medical executives in the Chief Medical Director's office, and provide that persons appointed to the office may return to previous title 38 positions after tours of duty in the office of the Chief Medical Director.

Require the establishment of procedures governing performance review of health care personnel during the probationary period of employment (2 years).

Provide authority to pay technical medical specialists to be on-call for duty, in addition to their regular hours of employment, without the requirement that they remain on the facility grounds.

Allow waiver of licensure of medical personnel whose duties do not include patient care, but only in research or academic type posts or where the duty station and the licensure are in a country other than the United States.

Clarify the statute of limitations applicable to suits brought by the United States to recover costs of Veterans' Administration health care. Expand immunity from personal liability for VA health care providers. Remove a statutory limitation on the authority of the Administrator of Veterans' Affairs to settle administrative tort claims under the Federal Tort Claims Act by providing authority to settle claims on the same basis as is currently afforded to U.S. attorneys.

Prohibit transfer to another Federal agency or to a State of any interest in real property owned by the United States and administered by the Veterans' Administration which has a value estimated at more than \$50,000, unless the transfer is explicitly authorized by law.

Provide that Canteen Service Revolving Funds may be deposited in other interest-bearing accounts in addition to a checking account with the Treasury of the United States, and also provide that any balance remaining in the Revolving Fund at the close of a fiscal year shall no longer be required to revert to the Treasury.

Provide that persons employed by the Canteen Service may not be considered to be Veterans' Administration employees for purposes of any personnel ceiling which may otherwise be applied to VA employees by the President.

Require that Canteen Service funds sequestered under the Gramm-Rudman-Hollings Act, Public Law 99-177, shall be returned to the Canteen Service Revolving Fund.

Require a pilot program to determine the effect of judicious freedom from restrictions in law, regulation, and administrative policy on the ability of medical center directors to efficiently manage their institutions.

Direct the Administrator of Veterans' Affairs to establish and operate an outpatient clinic in central or southern New Jersey and to begin the site location process for such clinic no later than 30 days after date of enactment of this legislation.

Name the Veterans' Administration Medical Center in Shreveport, Louisiana as the "Overton Brooks Veterans' Administration Medical Center."

BACKGROUND AND DISCUSSION

Eligibility for Medical Services

The Veterans' Benefits and Services Provisions of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, substantially changed eligibility for VA medical services by requiring the VA to provide needed hospital care for a category of eligible veterans that has come to be known as Category A. Category A veterans are: veterans with service-connected disabilities; former prisoners of war; veterans exposed to certain herbicides and ionizing radiation; veterans disabled as a result of VA treatment or vocational rehabilitation; veterans of the Spanish-American war, Mexican border period, or World War I; and non-service-connected veterans with one dependent whose income does not exceed \$15,195 for a veteran with no dependents (or \$18,234 for a veteran with one dependent, increased by \$1,013 for each additional dependent).

Under the provisions of Public Law 99-272, veterans other than those in Category A remained eligible for VA hospital care with certain modifications. The modifications resulted in two groups of eligible veterans which are known as Category B and Category C. The VA may provide needed hospital care to these veterans to the extent that VA resources and facilities are available. Category B eligibility includes those non-service-connected veterans whose incomes exceed \$15,195 (but do not exceed \$20,260) for a single veteran and \$18,234 (but do not exceed \$25,325) for a veteran with one dependent plus \$1,013 for each additional dependent). Category C eligibility includes those non-service-connected veterans whose incomes exceed \$20,260 for a single veteran and \$25,325 for a veteran with one dependent, plus \$1,013 for each additional dependent; the VA can provide needed hospital care to the extent that VA resources and facilities are available and provided that the veteran agrees to pay a nominal fee.

Despite difficulties anticipated by the VA, Public Law 99-272 was smoothly implemented by the VA. In its initial report to Congress and in follow-up reports, the proportion of care delivered to Category A veterans is approximately 95 percent; to Category B, approximately 2.5 percent; and to Category C, approximately 2.5 percent.

Public Law 99-272 did not change eligibility for outpatient care, nursing home care or other medical services, except to require that Category C eligible veterans be required to pay a nominal fee in connection with the receipt of services. Eligibility for outpatient services both before and after the enactment of Public Law 99-272 is more limited than eligibility for inpatient care. Current law authorizes outpatient treatment, except for dental services, for a veteran who seeks treatment for a service-connected disability. Current law also authorizes outpatient treatment, except for dental services, for a veteran with a service-connected disability rated 50 percent or more, or who is a former prisoner of war. Existing provisions of law grant similar eligibility for outpatient care to veterans of World War I, the Mexican Border period, the Spanish-American War, or to those who are entitled to increased pension based on the need of regular aid and attendance or by reason of being permanently housebound. All of these veterans who are eligible for outpatient care may be denied such care if VA facilities are not available to provide it. Moreover, veterans with service-connected disabilities rated less than 50 percent seeking treatment for a non-service-connected condition, as well as all other non-service-connected veterans, are eligible for outpatient services only to obviate the need for VA hospital care, in preparation for hospital care, or to complete treatment begun in the hospital. Once again, the restriction of providing care "within the limits of VA facilities" applies, so that on a given day all eligible veterans or 10 percent of eligible veterans, or, hypothetically, no eligible veterans, may be provided necessary care.

Section 101 of the reported bill would require that the VA "shall" provide outpatient care, except for dental services, to service-connected veterans for their service-connected conditions and for all but dental conditions of service-connected veterans rated at 50 percent or greater disability and of former prisoners of war. In addition, the reported bill would require that the VA "shall" provide outpatient care to Category A veterans in order to obviate the need for, in preparation for and as follow-up to hospital care. The reported bill would not change eligibility for outpatient care for Category B and Category C veterans.

By mandating health care to a limited, defined group of veterans, veterans would be able to predict the likelihood of receiving care from the VA and the VA and the Congress would have a basis for allocation of resources. The VA is authorized to continue providing care to the extent possible to an additional group of veterans where space is available and, in certain cases, where the veteran voluntarily agrees to pay a certain fee in connection with the receipt of care. The committee believes that, instead of trying to shrink the pool of eligible veterans without any mandate to provide care for those veterans who remain eligible, the Federal Government should clearly identify those veterans who, as a matter of public policy, should receive health care, and mandate that they be provided care in VA facilities.

In a directly related issue, the committee underscores the testimony presented in hearings that outpatient services are much less expensive than service provided on an inpatient basis. The committee perceives that a statutory entitlement only for hospital care

may provide an incentive for delivering needed care on an inpatient basis. The mandate in the reported bill to provide needed outpatient care to obviate the need for hospital care should neutralize this bias so that the locus for care can be decided on the basis of good medical judgment. The mandate to provide needed care in preparation for and as follow-up to hospital care should provide incentives to reduce lengths of hospital stays yielding medical and economic advantages.

The committee anticipates that solidifying the VA's authority to provide on an outpatient basis services which have heretofore necessarily been provided to inpatients only, coupled with the lower cost of outpatient care, will allow the VA to provide cost-effective services to more veterans. The VA has the capacity to respond in areas where there is a high demand for outpatient care by shifting resources to meet such demands.

The committee understands that any decision to provide inpatient or outpatient care is a medical decision. Nothing in the reported bill seeks to interfere with such decisions. The committee expects that each veteran eligible under the new mandatory eligibility for outpatient care will receive an examination to determine his or her medical need for outpatient care to obviate the need for hospital care and in preparation for or as follow-up to hospital care in addition to the routine examination with regard to his or her need for emergency care.

Domiciliary Care

Current law provides that the compensable service-connected veteran must have a permanent disability or require domiciliary care for tuberculosis or a neuropsychiatric condition and be incapacitated from earning a living and have no adequate means of support in order to be eligible for domiciliary care. The non-service-connected veteran need only meet the requirement of no adequate means of support.

Section 102 of the reported bill would clarify and correct the disparity between service-connected and non-service-connected veterans with respect to domiciliary care eligibility requirements by authorizing the VA to furnish domiciliary care to veterans who are in need of domiciliary care if such veterans are unable to defray the expenses of necessary domiciliary care.

The committee believes that the long-standing emphasis on providing services to service-connected veterans should be continued. The committee intends that this provision would remove barriers to domiciliary care which do not exist for non-service-connected veterans. In H.R. 1827, the Supplemental Appropriations for fiscal year 1987, the committee emphasized the role that domiciliary care, as an existing program in the VA, should play in addressing the problem of homelessness. As of the date of submission of this report, the differences in the House and Senate versions of H.R. 1827 are being resolved in conference.

Definition of Nursing Home Care

When the Medicare and Medicaid programs were created in 1972, the terms "skilled care" and "intermediate care" came into wide use throughout the health care industry as a method of iden-

tifying and describing the levels of care provided in nursing homes. However, in section 101 (28) of title 38, U.S.C., the statutory definition of the term "nursing home care" was adopted prior to the Medicare/Medicaid programs. This definition represents the full range of VA nursing care services provided to veterans from the highest level of skilled nursing care to a less intensive level of nursing care services, although it does not refer specifically to "intermediate nursing home care". This problem is magnified by section 620 of title 38, U.S.C., which is related to the VA's Community Nursing Home Program and which uses the term "intermediate care" as well as the term "skilled care" to include both skilled and intermediate levels of care.

Section 103 of the reported bill would clarify existing VA authorities by modifying the definition of "nursing home care" to include services delivered in skilled, intermediate care, and combined facilities and to exclude domiciliary or residential care.

Definition of Veterans' Administration Facilities

According to the Veterans' Administration, the Department of Medicine and Surgery has long provided veteran patients with therapeutic recreational services in meeting its statutory mandate to provide complete medical and hospital services. Such recreation programs include field trips and similar supervised outings which permit patients to participate in community activities. However, the authority to provide such activities is ambiguous.

Section 104 of the reported bill would clarify VA's authority to furnish veterans receiving VA care with therapeutic recreational activities outside the confines of a VA facility. The committee understands the value such rehabilitative services would have for certain patients who are preparing to return to their communities and supports its continued provision where medically appropriate.

Authorized Contract Care

Under existing law, the VA lacks the authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense. Current law provides that the VA may provide emergency care to veterans receiving medical services in a VA facility. The definition of VA facilities in title 38 does not include public or private nursing homes in the community.

The committee is concerned that some community nursing homes with whom the VA contracts for care are becoming unwilling to accept VA patients who have no means of financing hospital care in the event of a medical emergency. While such authority is infrequently needed, it is important in cases where such community nursing homes are located at some distance from VA hospital facilities.

Section 105 of the reported bill would authorize the VA to pay for emergency care for veterans placed in community nursing homes at VA expense.

Entitlement for Medical Services for Persons Disabled by Treatment or Vocational Rehabilitation

Under current law, persons injured by VA treatment or vocational rehabilitation are eligible as if service-connected for treatment in VA hospitals and nursing homes for conditions caused by the injury. However, such persons are eligible for only limited outpatient services.

Section 106 of the reported bill would make persons disabled by VA treatment, examination, or vocational rehabilitation eligible for outpatient care to the same degree as service-connected veterans. The committee intends that the outpatient care could be furnished only for the disability for which the person is receiving compensation under section 351 of 38 U.S.C.

Relocation of Vietnam Veterans Readjustment Counseling Centers

Before the enactment of Public Law 99-576, the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, section 612A(g)(1) of title 38, U.S.C., required that the Vietnam Veterans Readjustment Counseling Program (Vet Center) change by October 1, 1988 from a program in which services are delivered primarily in centers situated apart from VA health-care facilities to one in which services are primarily delivered through such VA health-care facilities. Public Law 99-576 extended the transition period for the Vietnam Veteran Readjustment Counseling Program from 12 months to 24 months ending on September 30, 1989 and added a requirement that the transition be gradual.

There are two statutory reporting requirements related to the transition: (1) a report, due April 1, 1987, on the Administrator's evaluation of the effectiveness of the Vet Center program and (2) a report, due July 1, 1987, containing a description of the plans made, and the timetable for, carrying out the transition. Both of these reports are required to take into account the study mandated under Public Law 98-160 on the prevalence and incidence of post-traumatic stress disorder (PTSD) and other post-war psychological problems in Vietnam veterans. However, the PTSD study had been delayed due to methodological difficulties. Therefore, Public Law 99-576 modified the two reports to specify that the two transition reports should be prepared and submitted taking into account whatever information from the PTSD study is then available.

To date, the committee, despite written communication with the VA, has not received the April 1, 1987 report on the Administrator's evaluation of the effectiveness of the Vet Center program in helping to meet the readjustment needs of veterans eligible for Vet Center counseling services. Therefore, the committee is unclear as to the VA's intentions regarding the Vet Center program. In particular, the committee has not been advised of the relationship between the VA's announcement that 9 Vet Centers are to be physically relocated into VA medical centers during the summer and early fall of 1987 and the VA's plans for the national Readjustment Counseling Program. These nine centers include: Avon, Massachusetts; Rochester, New York; Wilmington, Delaware; Fayetteville, North Carolina; Milwaukee, Wisconsin; Oakpark, Illinois; Sioux Falls, South Dakota; Northridge, California; and Houston, Texas.

The committee understands that five Vet Centers are to be relocated to VA Medical Centers by July 16, 1987.

The committee is concerned that there is no national plan for the operation of the Vet Center program. The stated intention of the VA in proposing to relocate nine centers is to gain experience in such moves. The Committee believes that the anticipated experience is not useful in the absence of a national plan.

Section 107 of the reported bill would prohibit the transfer or relocation of any center after the date of enactment of the bill until 120 days after the date of receipt by the Committees on Veterans' Affairs of the Senate and House of Representatives of the two required reports described above. The bill would also require that the plans and timetable report also include a detailed explanation and justification for the plan.

Contract Adult Day Health Care Program

Public Law 98-160 authorized, through September 30, 1988, veterans eligible under section 620 of title 38, U.S.C., for community (non-VA) nursing home care to be furnished day health-care services in non-VA programs at VA expense and in programs operated by the VA itself. Public Law 98-160 also provided that, following implementation of the adult day health-care authority, the VA would be required to conduct a study of the medical efficacy and cost-effectiveness of furnishing adult day health care and submit a report on the study on February 1, 1988.

The VA reports having furnished adult day health care in VA facilities under this authority since the summer of 1985, but has not yet begun a study of the care provided as required in Public Law 98-160. That study is expected to begin in the Spring of 1987 and continue through fiscal year 1990. Promulgation of authorizing regulations for contract facilities is expected in the Spring also. Thus, there will not be sufficient experience by February 1, 1988 to allow a study of the medical efficacy and cost-effectiveness of furnishing adult day health care.

Section 108 of the reported bill would extend for three years, through September 30, 1991, the authority for furnishing adult day health-care services under section 620(f) of title 38, U.S.C. In addition, section 108 would replace the requirement to report on the conduct of a study by February 1, 1988 with an interim report due on that date and with a final report due February 1, 1991.

The committee continues to believe that adult day health care is a promising alternative to institutionalization. The anticipated increase in the number of aging veterans will put great stress on the capacity of the VA to deliver long-term or extended care. Alternatives to institution-based care thus become important in a practical way as well as significant in allowing veterans to remain at home among family and friends for as long as is medically feasible. The committee urges the prompt commencement of the study in order to provide solid information concerning the provision of adult day health care.

Health Care and Medical Services Abroad

Current law (section 624 of title 38, U.S.C.) limits VA's authority to provide health care to service-connected veterans living or trav-

eling abroad to those persons who are United States citizens or who reside in the Philippines. Citizens of countries other than the United States who have service-connected conditions incurred in service in the U.S. armed forces may usually obtain care through a reciprocity arrangement between their country and the United States or by travelling to a VA facility in the U.S.

A special situation has arisen with regard to Canadian citizens who have service-connected conditions incurred while serving in U.S. armed forces during the Vietnam conflict. Canada was not a party to that conflict, so existing reciprocity agreements, whereby Canadian armed forces hospitals are reimbursed by the U.S. for the costs of such service-connected care, do not apply as in cases of veterans of World War I, World War II, and the Korean conflict. Further complicating the situation for Canadian citizens who are Vietnam veterans with service-connected conditions is the fact that Canadian law prohibits receipt of medical care for war-related conditions from provincial medical care facilities. Thus, Canadian citizens who have service-connected conditions incurred in Vietnam as members of the U.S. armed forces may only obtain care for their service-connected conditions by traveling to a VA facility in the U.S.

Section 109 of the reported bill would allow such Canadian citizens medical care for their service-connected conditions on a reimbursable basis by the VA. The committee believes that simple equity calls for a special modification of current law to allow the approximately 1200 such service-connected Canadian citizens to obtain care for their service-connected conditions. Testimony received from the VA suggested that a general relaxation of the citizenship requirement to receive fee-basis service-connected care. The only situation reported by the VA related to Canada, so the committee limited this provision to our northerly neighbor.

Repeal of Requirement for Annual Report on Contract Care

Section 201(b) of Public Law 96-22, the Veterans' Health Care Amendments of 1979 requires the submission of an annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the VA's use of its contract and fee-basis medical services authority. The reports were to have included in detail the number of veterans provided fee-basis and contract health care under each of the statutory eligibility categories and types of medical care, the cost for each of these categories, and the average length of care.

Only one report has been submitted (April of 1980, reporting data for the period from October 1, 1979, to December 31, 1979). According to the VA, the cost was \$1.17 million to collect the data. At the time of that report, the VA determined that the system required to collect the data would be too complex and would require automated data processing resources which were not available to the VA. The VA requested waivers in 1981 and 1982 of the reporting requirement from the Committees on Veterans' Affairs and data are no longer being collected from VA medical facilities.

The reported bill (section 110) would repeal the reporting requirement. However, the committee emphasizes that the responsibility for careful monitoring of the expenditures of contract and

fee-basis funds remains. The committee notes the status and success of the Decentralized Hospital Computer Program (DHCP). The committee views the growing sophistication of VA's medical information system, based on evidence of the capacity to record in detail the experience of the VA under Public Law 99-272, as providing an opportunity to design a monitoring system for contract and fee-basis funds. The committee expects that by January of 1988, the VA will have developed such a system for its own use in financial management. The committee intends to continue its close oversight of this important aspect of VA medical care.

Pilot Program on Contract Community-Based Residential Care

There has been considerable hearing testimony, broadcast media reports, and editorials concerning the type and scope of problems relating to homeless persons. The number of homeless persons who suffer from chronic mental illness and the number of homeless persons who are eligible for veterans benefits are unknown, but most estimates suggest that many homeless may be eligible for veterans benefits and that a large proportion of the homeless are chronically mentally ill. There is certainly evidence that the movement begun in the 1960's to "deinstitutionalize" patients in mental hospitals has resulted in a large number of homeless former mental patients. The absence of follow-up mechanisms and fragmented fiscal and management controls are, to a certain extent, thought to be responsible in part for the unhappy results of deinstitutionalization.

In Public Law 99-576, the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, the Congress required the VA to submit by December 15, 1987, a report to the Committees of Veterans' Affairs on the implementation of the VA's existing contract care authorities and the VA's expanded home health services authority for eligible chronically mentally ill veterans. In explanatory language, the Committees expressed support for the VA's development of a demonstration project in Region 1 of the VA's Department of Medicine and Surgery to provide, when medically appropriate and otherwise feasible, community-based treatment services for eligible chronically mentally ill veterans. In addition, the Committees reiterated their interest in the results of a review of the VA's patient population, particularly elderly veterans and chronically mentally ill veterans who are currently receiving care in VA facilities, to determine what percentage of them could receive needed care in noninstitutional settings if appropriate alternatives were available. The Committees initiated this review in a letter to the VA and also requested that the VA review the types of health and health-related services and alternative health-care settings that would enable veterans to avoid the institutional care that the VA would otherwise be required to furnish to them.

Section 2, Treatment and Rehabilitation for Chronically Mentally Ill Veterans, of Public Law 100-6, making emergency additional funds available for fiscal year 1987 for the Emergency Food and Shelter Program of the Federal Emergency Management Agency, provided for the transfer to the VA medical care account of some \$5 million from funds previously appropriated for fiscal year 1987, to be available through the end of fiscal year 1987 to carry out the new contract authority granted to the VA in that law. This con-

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tract authority, codified at section 620 (C) of title 38, U.S.C., would allow the VA to furnish community-based residential treatment to chronically mentally ill homeless veterans.

Section 111 of the reported bill would replace section 620 (C) of title 38, U.S.C., with a one-year pilot program to provide community-based residential care to homeless chronically mentally ill veterans. The reported bill would also authorize appropriations of \$6 million in fiscal year 1988 for the program and would require that not less than \$250,000 of such monies be devoted to management and monitoring of the program. The evidence is very strong that management of noninstitutional mental health care, treatment, and monitoring of the patients can prevent the occurrence of neglect of former mental patients after they leave mental hospitals. The committee, by setting aside monies, emphasizes the continued responsibility of the VA for patients receiving care under the authority of the VA. The Administrator would be required to submit a report on the VA's experience under this pilot program not later than May 1, 1988.

Pay Scales for Department of Medicine and Surgery

Section 4107 of title 38, U.S.C., contains a schedule of rates of basic pay for positions established in section 4103 of title 38 and for physicians, dentists, nurses, clinical podiatrists, and optometrists appointed under section 4104(1). These rates are linked to the other Federal pay rates and are increased from time to time, most recently under Executive Order 12578 of December 31, 1986.

Section 201 of the reported bill would update the pay rates for section 4103 positions in the VA's Department of Medicine and Surgery. The reported bill would not authorize any pay raises and would not entail any additional cost to the government.

Miscellaneous Medical Personnel Matters

At a hearing on April 22, 1987, the Committee received testimony that the shortage of health care personnel, particularly nursing personnel, widely reported in various media throughout the country, is also a critical problem in the VA's Department of Medicine and Surgery. This testimony reinforced correspondence received by many members of the committee reporting serious recruitment and retention problems around the country. Singled out in the testimony and correspondence were significant problems in recruiting and retaining registered nurses and pharmacists. A survey conducted by the VA showed that 54.5 percent of medical centers reported moderate to severe difficulty in recruitment and retention of registered nurses. The committee's own personnel survey revealed a large number of medical centers reporting significant personnel shortages in nursing and pharmacy.

Problems related to implementation and funding of the title 38 special pay rates, payment of Saturday premium pay and tuition assistance and/or reimbursement were cited as specific areas where action could be taken to help in the recruitment and retention of nurses. Currently, section 4107(e)(3) of title 38 requires VA to pay a registered nurse additional pay equal to 25 percent of the nurse's hourly rate of basic pay for duty on Sunday.

Section 202 of the reported bill would require the VA to provide premium pay for duty on Saturday using the same criteria currently used for Sunday premium pay. The committee acknowledges that this provision is insufficient to fully combat the current shortage of nurses being faced by the VA. However, the committee notes that emphasis on this provision was reiterated in testimony by several witnesses.

With regard to difficulties in recruiting qualified pharmacists, the situation is different from nurses in that title 5 personnel procedures govern their employment. The flexibility to increase pay found in title 38 is currently not available to title 5 employees. Section 202 of the reported bill would allow the VA to set rates of pay and qualifications standards for registered pharmacists in the same way that such authority was granted in Public Law 98-160 for certain other health care personnel specialties. Reports from the VA reveal that this authority aided the VA in recruiting certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses, thus easing the shortages of these professionals. Similar to the Public Law 98-160 pay authority, the committee emphasizes that it is not the intent of this provision to diminish or impair in any way the rights and protections guaranteed the pharmacists employed under the express provisions of chapter 71 of title 5, U.S.C., relating to Federal labor management relations.

Disciplinary Boards for Medical Personnel

Current law (38 U.S.C., section 4110) provides that all adverse personnel actions for employees appointed under title 38 U.S.C., section 4104, which are based on charges of inaptitude, inefficiency or misconduct will be heard by disciplinary boards. The VA reports that the current disciplinary board process is cumbersome and overburdened since no distinction is made between more or less severe adverse personnel actions. As a result of the current cumbersome process, long delays occur in the actions of the disciplinary boards.

During the 99th Congress, the committee attempted to address the problems in disciplinary boards as part of H.R. 4623. H.R. 4623, as reported, would have changed the circumstances under which the disciplinary board system would be used for the Department of Medicine and Surgery employees of the VA who are appointed under the title 38, U.S.C., medical personnel system. It would have done this by limiting the appointment of such boards to disciplinary actions involving suspensions exceeding 14 calendar days, demotions involving a loss of grade or pay, and discharges of employees. This provision of H.R. 4623 was not accepted by the Senate as part of the legislation that became Public Law 99-576, the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986.

Section 203 of the reported bill would provide the same remedy to the problems in disciplinary boards as was attempted by H.R. 4623 in the previous Congress. The committee intends that an administrative appeal or grievance procedure would be established for suspensions of less than 14 calendar days, directed transfers between VA facilities, directed reassignments within VA facilities, re-

ductions-in-rank without a corresponding reduction in grade or pay, and changes in duty assignments. Section 203 would not affect the existing right to appeal to the Administrator in section 4110 cases and the committee intends that appeal rights accorded under other Federal statutes will be applicable for the resolution of disputes other than the covered disciplinary actions.

The committee's purpose in reporting this provision is to improve the current cumbersome and overburdened disciplinary board process by allowing it to focus on more severe personnel actions. It is important to note in this regard that the review intended by this provision for less severe actions would continue to protect employee interests and guard against arbitrary action.

Health Professional Scholarship Program

Current eligibility for scholarships under the VA's Health Professional Scholarship Program is limited to individuals accepted for enrollment, or enrolled, as a student in a course of training leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing, or to become a physician assistant or expanded-function dental auxiliary. Students who receive these scholarships are obligated to work for the VA for a certain length of time after their period of training.

The scholarship program has proved to be a highly successful method for recruiting and retaining health care professionals for the VA. For example, 73 percent of the full-time nursing students who participated in the scholarship program have stayed in the VA after their obligated service period, and as of April 23, 1987, all of the part-time scholarship participants have remained in VA employment.

Section 204 of the reported bill would expand the eligibility for the scholarship program for courses of study leading to qualification for employment in a position described in section 4104 of title 38, U.S.C. The additional positions covered by this provision include pharmacists, physical therapists, occupational therapists, medical and dental technologists and others. The committee believes that, with the current difficulty faced by the VA in recruiting pharmacists, physical therapists and other health professionals, the use of the scholarship program as a recruitment and retention device is well-advised in light of its previous success. It is the intent of the committee that all scholarship recipients assume the same obligations as are now prescribed for those currently eligible for the program.

Personnel Ceilings for Noncareer Research Personnel

During its hearing on the President's proposed fiscal year 1988 budget, the committee learned of restrictions on full-time equivalent employees (FTEE) for research in the VA and the effect of those restrictions on the ability of the VA to continue its significant research contributions. Like other VA programs, the research programs in medical, rehabilitation and health services have been limited in terms of FTEE. While funds available for these research programs have sometimes increased, the limits on FTEE restricted the use of those funds. As a result, funds for projects approved under merit review sometimes are unable to carry accompanying

authority for personnel, requiring each medical center to reallocate FTEE and to play off new programs against existing programs notwithstanding the availability of funds to conduct both. In addition, extramural funds accumulated in the General Post Fund for use in research activities can be used for personnel only by competing for the same pool of research FTEE. Since medical care personnel cannot be transferred for use in research, available research funds remain unused due to the lack of personnel.

A chief of staff at a VA medical facility with a large research program said at the February 4, 1987 fiscal year 1988 budget hearing, "As is the case at our affiliated medical school, we should be able to recruit the number of personnel justified by our funds and to keep such personnel so long as funds are available . . . in the same position as employees at the medical school who are recruited to meet the needs of a specific grant; they have no tenure beyond the duration of those grant funds."

Section 205 would exclude temporary research personnel from any ceiling on full-time equivalent employees of the VA or any other personnel ceiling otherwise applicable to employees of the VA. The term "temporary research personnel" means personnel who are employed by the VA in other than a career appointment for work on a research activity. The committee is proud of the numerous important contributions made to the Nation and the world by VA researchers and wishes to remove artificial restraints on VA research productivity based on the mistaken notion that temporary research personnel pose any long-term burden on the agency.

The committee notes the views of the VA that this legislative solution is not necessary due to the opportunity to adjust FTEE administratively on a case-by-case basis. However, the committee believes that the delays inherent in such an administrative solution might prove as restrictive as the current administratively imposed FTEE ceilings on temporary research personnel.

Office of the Chief Medical Director

Current law, codified at section 4102 of title 38, U.S.C., makes mandatory a structure for the Office of the Chief Medical Director in the VA's Department of Medicine and Surgery. This structure has resulted from a series of emphases over the years on certain programs and/or program activities. It is understandable that, as new fields are developed and new obstacles are discovered, certain modifications to that structure may be needed.

The VA has requested broad powers for the Chief Medical Director to unilaterally make any changes in the structure and configuration of the Office of Chief Medical Director. The committee believes that further discussion of these powers is required, especially relative to the geriatric specialist that is currently mandated in section 4102.

Section 206 of the reported bill would, however, without changing existing law as to the appointment, qualifications, or responsibilities of the Chief Medical Director and the Deputy Chief Medical Director, create a second Associate Deputy Chief Medical Director position.

Section 206 of the reported bill would also entitle to reemployment any person who is appointed to a position under section

4104(1) of title 38 and whose appointment is terminated under section 4104(1).

Disciplinary Actions Concerning Probationary Employees

Existing law does not prescribe any procedures for disciplinary actions concerning probationary employees. Currently, the Chief Medical Director of the VA's Department of Medicine and Surgery plays no substantive role in the reviews of the performance of probationary medical professionals.

In order to establish in statute the rights of probationary employees, section 207 of the reported bill would specify as the probationary period the first two years of employment of a person appointed under section 4104(1) of title 38, U.S.C. (physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries).

The committee intends that this section would clarify the power of the Administrator of Veterans' Affairs with regard to the prescription by regulation, both of the procedures to be followed by the board reviewing the performance of probationary employees, and the circumstances in which proceedings may be initiated. Additionally, the committee intends to clarify that final action in the review process should be taken by the Chief Medical Director.

On-Call Pay for Certain Personnel

The VA must ensure that certain health-care support personnel, such as x-ray, laboratory, operating room and other technologists and technicians, are available in medical emergencies or for unforeseen medical needs which occur outside their regular duty hours. This group of personnel may be appointed under title 5 or title 38, U.S.C., depending on their skills, and are currently placed in a "standby" duty status whereby they are physically confined to their duty stations and are paid standby duty premium pay mandated by section 5545 of title 5, U.S.C., whether or not they are, in fact, called to work.

In contrast to "standby" status, personnel on "on-call" status are subject to being called back to work outside of regular tours of duty, but their physical movements are not confined to a designated duty station. On-call duty personnel may arrange for others to respond to a call or may leave a telephone number at which they can be reached should their services be required. Title 5 employees are not paid while in an "on-call" status; if called back to work they receive overtime pay for the time actually worked (with a minimum of two hours overtime pay, regardless of actual time worked). The benefits to employee morale and reduced costs relative to the necessity of having such personnel on standby are clear to the committee.

Section 208 of the reported bill would provide VA with the authority to require and pay title 5 employees to be "on-call" in the same manner that "on-call" pay is provided to title 38 personnel.

Waiver of Licensure Requirements for Certain Personnel

Section 4105 of title 38, U.S.C., requires registered nurses, practical or vocational nurses, and physical therapists along with physicians, nurses, dentists and other health care professionals to be li-

censed or registered in a State in order to be eligible for appointment in the VA's Department of Medicine and Surgery. No authority exists in title 38 for waiver of licensure or registration for permanent employees appointed pursuant to section 4104. However, section 4114 authorizes the Chief Medical Director to waive the State licensure or registration requirements for physicians, dentists, podiatrists, psychologists, or optometrists, where those professionals are being appointed on a temporary or part-time basis to research or academic posts or where there is no direct patient care responsibility.

The VA has testified that existing waiver authorities have allowed the agency to staff VA research and academic activities. However, in the few cases where the VA needs a registered nurse, a practical or vocational nurse, or a physical therapist in a purely academic or research temporary full or part-time role, the appointee must still meet the requirement for licensure, even though he or she will not engage in patient care.

In a related situation, the Chief Medical Director may waive the requirement for State licensure or registration for physicians, dentists, podiatrists, psychologists, or optometrists and registered nurses where the person is to serve the VA on a temporary full or part-time basis in a foreign country and where the person has licensure or registration in the country where the person is to serve. This authority has been useful in staffing the only foreign country VA health care installation at Manila, the Philippines. However, in Manila, the requirement for licensure in a State still applies to licensed or vocational nurses, and physical therapists. Thus, even though these persons have licensure or registration in the Philippines and will not be practicing their profession in any State, under current law they must still be licensed in a State.

Section 209 of the reported bill would authorize the Chief Medical Director to waive the requirement in section 4104(a) of title 38, U.S.C., that the licensure or registration, as appropriate, of a physician, dentist, practical or vocational nurse, or physical therapist, be in a State if the person to be appointed is (1) to be employed in a research post or an academic post or where there is otherwise no direct responsibility for the care of patients or (2) to serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.

The committee stresses that this provision is intended to promote the VA's medical research and education programs by providing the Chief Medical Director with additional flexibility to appoint nonlicensed practical or vocational nurses, physical therapists, and registered nurses to research or academic assignments. The waiver authority contained in the reported bill is not intended to apply to, and would not be used in connection with, the appointment of a person who has any patient care responsibilities or duties. The waiver authority is also intended to assist the VA outpatient clinic in Manila in providing quality health-care to veterans by permitting the appointment of temporary full or part-time practical or vocational nurses or physical therapists who are licensed only in the Philippines to serve in that facility.

The committee is relying on VA testimony that the waiver authority is anticipated to be used sparingly. The committee urges

that, where possible, persons with State licensure and/or registration be employed in academic and research positions in the belief that knowledge of direct patient care will have a beneficial effect in such activities.

Hospital Cost Collections and Tort Claims

In 1986, the Congress enacted and the President signed a substantial revision to the Veterans' Administration's authority to collect from third-party payers the cost of care provided to veterans. However, the limitation in time for bringing legal actions to recover such obligations is not specifically set forth in the statute. In order to clarify the statute of limitations applicable to suits brought by the United States to recover these debts, the bill would establish a 6-year statute of limitations and would also designate the last day of treatment for which recovery is sought as the date on which the statute of limitations begins to run.

For many years, VA medical personnel have been protected from personal liability in medical malpractice actions arising out of allegedly negligent conduct in the furnishing of medical care or treatment to veterans. However, the Government does not extend this immunity to actions arising out of intentional conduct—so-called "intentional torts". In some instances, State law characterizes an act of medical malpractice as an intentional tort, leaving VA medical personnel potentially liable for an action for which the law intends the Government to assume liability. As an example, if a patient consents to an operation on his left elbow, but the physician mistakenly operates on the right elbow, responsibility for this action would lie with the United States. However, if the suit was based on a theory that a battery occurred, which is defined as any contact with a person without that person's consent, the Government is not allowed to assume the employee's liability. In essence, State law, which controls the character of the action brought against VA medical personnel, could defeat the intent of the Federal law to provide such employees with immunity. Therefore, the reported bill (section 301) would extend the same degree of protection to VA health care personnel as is currently afforded similar personnel in other Federal agencies.

This same section of the reported bill would replace the current \$25,000 limitation on the authority of the Administrator of Veterans' Affairs to settle administrative tort claims with a delegation of settlement authority not exceeding the authority delegated by the U.S. Attorney General to U.S. attorneys. That amount currently is \$200,000. The present limitation is now over 20 years old, and an increase in this authority will permit speedier resolution of claims and swifter compensation to injured parties. The Attorney General supports this increase in the Administrator's authority.

Limitation on Property Transfers to Other Agencies

Last year, during the consideration of various Veterans' Administration proposals to declare excess certain parcels of land in southern California, it became clear that the administration had embarked on a policy of selling marketable vacant land owned by the Government. Notwithstanding the Committee's opposition to this policy, the Administrator continues to propose to declare as

excess vacant property administered by the Veterans' Administration.

During the 99th Congress, the committee reported H.R. 4623, which included a provision prohibiting the Administrator from declaring certain property excess. The Committee Report (H. Rept. No. 99-729) contained a brief history of the committee's concern over the increasing pressure on the Administrator to declare vacant land excess to VA needs. The committee is determined to assure the availability of land to meet the future needs of the Department of Medicine and Surgery, the Department of Veterans Benefits, and the Department of Memorial Affairs. Accordingly, the reported bill (section 302) would prohibit the Administrator from transferring any interest in land administered by the Veterans' Administration, with a value in excess of \$50,000, unless specifically approved by an act of Congress. As a further disincentive to policy makers who consider the projected revenue from such land sales to be a means of offsetting costs unrelated to veteran programs, the bill would also require that any proceeds from the sale of lands administered by the Veterans' Administration be deposited in the parking revolving fund in order that such funds could be used to benefit veterans, their families, and VA employees.

Financial Management of Canteen Service

During the 99th Congress, the Subcommittee on Oversight and Investigations held two hearings on problems faced by the Veterans Canteen Service (VCS). Testimony was heard from several former directors of the VCS, marketing experts, and local Canteen Service chiefs. It became apparent to members of the committee that a concerted effort was being made by the VA to fundamentally alter the operation of the VCS in derogation of the law which established it. Fortunately, the committee's oversight persuaded the Veterans' Administration to alter several of its announced plans to restructure the management of VCS, and some 15 months after the former director retired, a new director was finally named. The committee plans to monitor closely the efforts of the new management team to regain some of the ground lost as a result of the unprecedented vacuum in the leadership of this service.

As part of its efforts to insure the continued viability of the VCS, the committee believes that certain financial reforms are necessary. Existing law is silent as to authority to invest VCS funds in interest bearing accounts. Prudent financial management calls for investment of funds which are not needed to meet current VCS demands. Since the fund is a self-supporting fund which is required to operate in a business-like manner, the committee believes that explicit authority to invest surplus funds is consistent with the goals and mission of the VCS. In addition, the fund should be encouraged to use surplus funds derived from operations for capital improvements, consistent with sound business practices. The Anti-Deficiency Act applies to the fund and prohibits it from operating at a sustained loss. Existing law, however, calls for funds in excess of the requirements for the ensuing fiscal year to be returned to the Treasury. Because this fund has not received any appropriations since the initial capital investment made almost forty years

ago, the committee believes that the existing law discourages sound financial planning and is no longer justified. The VCS has returned over \$12 million to the Treasury under this provision, an amount far in excess of the approximately \$5 million in appropriated funds which it initially received. Therefore, the reported bill (section 303) would authorize retention of balances in the revolving fund.

Exemption of Canteen Service From Personnel Ceilings

The imposition of personnel ceilings on agencies by the Office of Management and Budget is one means of controlling the costs of operating an agency. Businesses control their costs through a variety of methods; if they fail to do so, they lose money and eventually go out of business. This elementary contrast between a Federal agency and a private enterprise has not stopped the Office of Management and Budget from imposing personnel ceilings on the VCS. Since the VCS is required to support its own operations, it has business-type incentives to control costs, including personnel costs. To subject the VCS to an arbitrary ceiling on the number of personnel it may employ inevitably results in less-than-sound business judgments. Accordingly, the reported bill (section 304) would exempt the VCS from arbitrary and counter-productive personnel ceilings.

Restoration of Certain Funds to the Canteen Service

During the 99th Congress, legislation was enacted to exempt the VCS from the sequestration provisions of the Balanced Budget and Emergency Deficit Control Act of 1985, Public Law 99-177 (Gramm-Rudman-Hollings). At the time that the respective houses were considering this legislation, it was the understanding of the House and Senate Committees on Veterans' Affairs that the 1986 sequestration order would only impose a limit on the obligations incurred in VCS. Accordingly, the legislation adopted reflected this understanding. Subsequently, the Congress learned that the Office of Management and Budget had required the Veterans' Administration to withdraw \$8.1 million from this self-supporting account and pay it to the Treasury. These funds were profits from operations that were intended to be used for capital investment in fiscal year 1987. As a result of OMB's decision, VCS was forced to raise prices on goods sold to veterans, reduce hours of operation, and delay needed replacement of aging equipment. The return of this money to the fund will enable VCS to reduce costs and purchase necessary replacement equipment. Therefore, the reported bill (section 305) would require the Secretary of the Treasury to return the \$8.1 million to the VCS within 60 days of the date of enactment of this legislation.

Pilot Program on Hospital Management Efficiency

During the 99th Congress, the committee reported a provision which was included in H.R. 4623 which would have directed the Administrator to conduct a pilot program to assess whether greater efficiency could be achieved in the management of VA medical centers by removing limitations now imposed on medical center directors by selected laws, regulations, and administrative policy. The pilot program would have been implemented in five VA medical

centers designated by the Administrator after consultation with the Committees on Veterans' Affairs of the House and Senate. The program was to have been conducted for a 3-year period. This provision was deleted in conference with the Senate.

Section 306 of the reported bill contains the same provision. It is the committee's view that VA medical center directors must manage their facilities in an environment that is different from the environment faced by their counterparts in the private sector. The directors face constraints imposed by Federal laws and regulations which directors of non-Federal facilities do not face. At the same time, they are held to the same high standards by accrediting bodies, such as the Joint Commission on the Accreditation of Hospitals, as are hospitals in the private sector. The committee believes that some of those constraints on the authority of hospital directors may be unnecessary, and it may be possible to operate VA medical centers more efficiently and effectively if directors were freed from some of the limitations on their authority. To test that hypothesis, section 306 of the reported bill would direct the conduct of the pilot program.

The legal and regulatory provisions which it has been suggested may impede the efficient operation of VA medical centers—restrictions on financial management, personnel management, contracting, and travel, for example—are not in and of themselves unwise. Many of them were generally established to foster sound planning, to guard against imprudent spending, and to provide accountability. Nevertheless, the cumulative impact of these limitations is significant. It is the committee's intent that the VA lift selected limitations in 5 facilities in order to examine whether, freed of restrictions, directors could deliver services in a more timely, responsive, efficient, and effective manner, and still be fully accountable. The reported bill would direct that, as a part of the pilot project, the VA conduct a careful study of the affected facilities to determine the impact of lifting the various restrictions.

The committee is aware of the fact that the VA has formed a group of high level officials who have been examining the specific limitations and restrictions which may inhibit the management efficiency of medical center directors, and which they believe could be lifted without altering the mission of the facilities or in any way adversely affecting veteran beneficiaries. At committee hearings conducted earlier this year, VA officials testified that they do not contemplate sweeping waivers of statutes. They would not, and could not, abandon fundamental civil service laws or procurement laws, nor alter basic patient care eligibility and priority of care provisions. The committee agrees that such provisions should not be waived and also anticipates that this exceptional authority be very carefully exercised. The committee also does not intend that the VA disturb Federal labor laws such as the Fair Labor Standards Act and the Davis-Bacon Act, or that there be any effect on union bargaining rights or employee protections.

The committee believes that during the pilot program, it would be appropriate for the VA to waive the kinds of legal limitations that the VA group has identified, and which agency officials identified in testimony earlier this year. Suggested provisions to be waived consist of the following:

Lifting of specific funding constraints on when, and for what, the test facilities may obligate the allotted funds which they received from the Medical Care appropriations;

Authorization for the test facilities to carry over to the next fiscal year unobligated portions of their annual allotments from the Medical Care appropriation for the duration of the pilot program;

Lifting of employee travel funding restrictions; and,

Suspending mandatory participation of test facilities in A-76 studies, and waiver of section 5010(c) of title 38, U.S. Code regarding so-called "contracting out."

Additionally, it is the committee's understanding that the VA group has identified for waiver many administrative limitations such as those which require medical center directors to obtain VA Central Office approval before they act. VA might also seek delegation to the pilot site directors of authorities now held by other agencies, such as the Office of Personnel Management.

In reporting section 306 of the bill, the committee underscores its intent that the purpose of the pilot program would be to test whether increased management flexibility would improve the efficiency and economy of the operation of VA medical centers. The measure is not intended to achieve cost savings. Accordingly, the bill specifically provides that the Administrator must ensure that the pilot site medical centers do not incur any budget reduction during the pilot program due to any improved efficiency or economy attributable to conduct of the test.

Outpatient Clinic, New Jersey

Section 307 of the reported bill would require the Veterans' Administration to establish and operate an outpatient clinic in central or southern New Jersey. At the present time, the only VA medical facilities are located in the northern part of the State which requires the veterans residing in the southern or central areas either to travel long distances for their medical treatment or to seek care from other sources. The committee believes that a VA outpatient clinic located in the southern region of the State will provide a more cost-effective and responsive manner of treating the veterans of that part of New Jersey.

Name of Medical Center, Shreveport, Louisiana

Since 1945, 19 hospitals have been named by Congress in honor of Presidents of the United States and other distinguished individuals. Three other VA medical centers and one outpatient clinic have been named for distinguished persons other than by acts of Congress—by order of the Secretary of the Treasury in 1921, by the War Department in 1943 when a hospital was originally a facility of the U.S. Army, by the President in 1947, and by the Administrator of Veterans' Affairs in 1986.

H.R. 587, to name the Veterans' Administration Medical Center in Shreveport, Louisiana, as the "Overton Brooks Veterans' Administration Medical Center", was introduced on January 8, 1987 and cosponsored by the House Louisiana Congressional delegation as required by Committee rules.

Overton Brooks was devoted to advancing the interest of veterans and members of the armed forces reserves. During the 25 years Mr. Brooks served the 4th Congressional District of Louisiana, he was an avid supporter of legislation to increase compensation and dependency and indemnity compensation as well as the GI Bill. He worked diligently for the location of a Veterans' Administration hospital in Shreveport, Louisiana.

Overton Brooks was born in East Baton Rouge Parish, LA on December 21, 1897. He was educated in the schools of East Baton Rouge Parish and enlisted in the U.S. Army in July, 1918 and served in the Sixth Field Artillery, First Regular Army Division until September 1, 1919. He graduated from the Louisiana State University Law School on April 10, 1923 at which time he began the practice of law in Shreveport. He became a United States Commissioner on September 1, 1925 and served as such for 10 years. He was elected to the 75th through 87th Congresses and died in office on September 16, 1961. Mr. Brooks served as Chairman of the Committee on Science and Astronautics during the 86th Congress and was a member of The American Legion, Veterans of Foreign Wars and a thirty-second degree Mason.

Section 308 of the reported bill would name the Veterans' Administration Medical Center in Shreveport, Louisiana the "Overton Brooks Veterans' Administration Medical Center."

SECTION-BY-SECTION ANALYSIS OF H.R. 2616

TITLE I—HEALTH CARE PROVISIONS

Section 101

Would amend subsections (a) and (f) of section 612 of title 38, United States Code, to direct that the Administrator furnish medical services to so-called "Category A" veterans (*i.e.* those listed in section 610(a)(1)) to the extent of these veterans' eligibility for those services under existing law. Thus, under section 612(a) as amended, the law would call for the Administrator to provide needed outpatient care to any veteran for a service-connected disability and for any disability if the veteran is 50% or more service-connected. Under this provision, new section 612(f)(1)(A) would provide that the Administrator "shall" furnish outpatient medical care to other Category A veterans for the following purposes: in preparation for hospital admission, to obviate the need of hospital admission, and to complete treatment furnished during hospital, nursing home, or domiciliary care. In addition, section 612(f)(1)(B) would be amended to restate existing law with respect to the Administrator's authority to furnish outpatient care to Category B and C veterans. Section 101 would also make conforming amendments to section 603 of title 38.

Section 10.

Would amend section 610(b) of title 38 to clarify and correct a disparity between service-connected and non-service-connected veterans with respect to eligibility for domiciliary care. Currently, the law appears to impose more stringent requirements for domiciliary care on service-connected veterans than on other veterans. The

provision would establish a veteran's inability to defray the expenses of needed domiciliary care as a single criterion for eligibility.

Section 103

Would amend section 101(28) of title 38 to clarify the definition of "nursing home care" to provide that this term also includes skilled and intermediate levels of care.

Section 104

Would amend section 601(4) of title 38 to clarify the authority of VA to provide therapeutic recreational activities outside the confines of a VA facility to veterans receiving VA care.

Section 105

Would amend section 603(a) of title 38 to provide authority for VA-sponsored emergency hospital care for veterans who have been placed in community nursing homes at VA expense.

Section 106

Would amend section 612(a)(1) of title 38 to direct VA to provide persons disabled by VA treatment or vocational rehabilitation with outpatient medical services.

Section 107

Would prohibit VA from transferring a readjustment counseling center (Vet Center) to a VA health-care facility before a 120-day period after the Senate and House Committees on Veterans' Affairs receive reports from VA required by paragraphs 2 and 3 of section 612A(g) of title 38, United States Code, to be submitted on April 1 and July 1, 1987, respectively. The report required by paragraph 2 shall contain a detailed explanation and justification for the plan referred to in that paragraph.

Section 108

Would amend section 620(f)(3) of title 38 to extend VA's authority to provide adult day health care services through September 30, 1991. This authority would otherwise expire on September 30, 1988. This section would require VA to conduct a study of the medical efficacy and cost effectiveness of furnishing adult day health as an alternative to nursing home care and to compare the advantages and disadvantages of providing this care through VA facilities with those not under VA jurisdiction. This provision would require VA to submit to the Senate and House Committees on Veterans' Affairs an interim report on this study by February 1, 1988, and a final report by February 1, 1991. Each report must contain the results of the study by the date submitted with any appropriate recommendations for legislative and administrative action on furnishing adult day health care.

Section 109

Would amend section 624(b) of title 38 to provide VA with authority to furnish fee-basis care for service-connected disabilities of

Canadian citizens who served in the United States military forces and now reside in Canada.

Section 110

Would repeal section 201(b) of the Veterans' Health Care Amendments of 1979 (Public Law 96-22; 38 U.S.C., 601 note), which requires that VA submit an annual report on contract care.

Section 111

Would require that VA conduct, through September 30, 1988, a pilot program to provide care and treatment and rehabilitative services (by contract or otherwise) in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are eligible for hospital care as Category A veterans. VA must report to the Senate and House Committees on Veterans' Affairs by May 1, 1988, on VA's experience under the pilot program and make recommendations as to whether the program should be continued. This measure would authorize \$6 million for this program, of which not less than \$250,000 shall be used for management and monitoring.

TITLE II—HEALTH CARE PERSONNEL

Section 201

Would update the pay schedule in section 4107 of title 38 for employees of the Department of Medicine and Surgery appointed under sections 4103 and 4104(1) to conform with the current pay rates established by Executive Order 12578 (December 31, 1986).

Section 202

Subsection (a) would amend section 4107(e)(3) of title 38 to mandate that VA provide premium pay to registered nurses for Saturday duty at the rate now mandated for Sunday duty. VA is now required to pay a registered nurse additional pay equal to 25 percent of a nurse's hourly rate of basic pay for duty on Sunday.

Subsection (b) would amend section 4104 of title 38 to permit VA to set rates of pay and qualifications standards for pharmacists without regard to civil service law, rules, and regulations, in order to assist VA in recruiting and retaining pharmacists.

Section 203

Would amend section 4110 of title 38 to narrow the disciplinary actions against nonprobationary title 38 employees requiring review by Disciplinary Boards so as to require Board review only for removal, suspension for more than 14 days, or demotion involving loss of grade or pay and discharges of employees. Currently, Board review is also required for actions which would result in minor penalties. This section would also authorize VA to establish administrative procedures for less severe disciplinary actions.

Section 204

Would amend section 4142(a)(1) of title 38 to broaden eligibility for the VA Health Professionals Scholarship Program to include

all employees covered under section 4104 of title 38, such as pharmacists, psychologists, dieticians, occupational and licensed physical therapists, and licensed practical or vocational nurses. This section would also amend section 4144 of title 38 to provide that the individuals being made eligible for this program become liable to repay VA for the amount of the benefit in the event of failure to achieve licensure or other appropriate credential as do those now eligible for this program.

Section 205

Would amend section 5010(a) of title 38 to expressly exclude temporary research personnel employed by VA from any personnel ceiling placed on permanent full-time equivalent employees or from any other personnel ceiling applicable to VA employees.

Section 206

Would amend section 4103 of title 38 to authorize the appointment of a second Associate Deputy Chief Medical Director. As amended, section 4103 would also guarantee medical executives in the Office of Chief Medical Director the right to the disciplinary board procedures under section 4110 of title 38 in cases of removal for cause, and provide reemployment rights to such an executive when the appointment to the Office of the Chief Medical Director expires if the employee had previously relinquished an appointment under section 4104(1) of title 38.

Section 207

Would amend section 4106(b) of title 38 to authorize VA to establish by regulation procedures governing the review of the performance of probationary employees appointed under section 4104(1) of title 38. This section would also clarify the authority of the Chief Medical Director to accept, reject, or modify the recommendations of the board reviewing the performance of a probationary employee.

Section 208

Would amend section 4107 of title 38 to authorize VA to provide "on-call" pay to civil service health-care personnel, such as X-ray, laboratory, operating room, and other technologists and technicians, for duty outside their regular duty hours.

Section 209

Would amend section 4114(d) to authorize the Chief Medical Director to waive the requirement of licensure, imposed by section 4105(a) to title 38 for medical personnel, but only if the individual is in a research or academic-type post or where there is no direct responsibility for patient care, or if the person's service is outside the United States and the person is licensed in the country in which the person is to serve.

TITLE III—ADMINISTRATION OF HEALTH-CARE SYSTEM

Section 301

Would make certain improvements in the administering of tort claims and hospital cost collections by VA.

Subsection (a) would amend section 629 of title 38 to clarify the 6-year statute of limitations for the United States to sue and to specify an accrual date.

Subsection (b) would amend section 4116 of title 38 to extend protection to VA health-care personnel from suits alleging commissions of certain so-called "intentional" torts during medical care or treatment, thereby bringing the protection afforded VA health-care personnel in line with that provided health-care personnel of other agencies.

Subsection (c) would amend Subchapter II of Chapter 3 of title 38 to remove the current \$25,000 limitation of the Agency to settle administrative tort claims under the Federal Tort Claims Act and replace it with such monetary authority as may be delegated to the Administrator by the Attorney General, not to exceed that authority delegated to the United States Attorney.

Section 302

Would amend section 5022(a) of title 38 to prohibit VA from transferring to another Federal agency or to a State any interest in real property owned by the United States and administered by VA which has an estimated value in excess of \$50,000 unless the transfer is explicitly authorized by law. Requires the proceeds from such a transfer to be deposited in the parking revolving fund.

Section 303

Would amend sections 4205 and 4206 of title 38 to provide that Canteen Service Revolving Funds may be deposited in other interest-bearing accounts, in addition to a checking account with the United States Treasury, and to provide that any balance remaining in the Revolving Fund at the close of a fiscal year shall no longer be required to revert to the Treasury.

Section 304

Would amend Chapter 75 of title 38 by adding a new section 4209 which would provide that persons employed by the Canteen Service may not be considered to be VA employees for purposes of any personnel ceiling which may otherwise be applied to VA employees by the President.

Section 305

Would return to the Canteen Service Revolving Fund any funds sequestered under the Gramm-Rudman-Hollings Act (Public Law 99-177).

Section 306

Would require VA to conduct a pilot program to determine the feasibility of operating VA medical centers free of certain statutory and regulatory constraints. Specifically, the Administrator would designate five VA medical centers at which each center's director,

pursuant to the Administrator's authorization, could waive or alter any laws and regulations applicable to the center's management and administration to determine the effect of the waivers of alterations on the efficiency and economy of the center. The authorization for this program would expire on September 30, 1990. The Administrator would be required to submit an annual report on the pilot program to Congress.

Section 307

Would require VA to establish and operate an outpatient clinic in central or southern New Jersey and to begin the site location process for this clinic no later than 30 days after the date of enactment of this legislation.

Section 308

Would designate the VA Medical Center in Shreveport, Louisiana, as the "Overton Brooks Veterans' Administration Medical Center."

OVERSIGHT FINDING

Oversight findings are included in the Background and Discussion section of this report.

No oversight findings have been submitted to the Committee by the Committee on Government Operations.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill.



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June 24, 1987

Honorable G.V. Montgomery
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In response to your request, CBO has prepared the attached cost estimate for H.R. 2616, the Veterans Administration Health-Care Amendments of 1987, as ordered reported by the House Committee on Veterans' Affairs, June 10, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

Edward M. Gramlich
Acting Director

cc: Honorable Gerald B.H. Solomon
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 24, 1987

1. BILL NUMBER: H.R. 2616
2. BILL TITLE:
The Veterans Administration Health-Care Amendments of 1987.
3. BILL STATUS:
As ordered reported by the House Committee on Veterans' Affairs, June 10, 1987.
4. BILL PURPOSE:
To improve health-care programs of the Veterans Administration (VA).
5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
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Budget Authority	1	1	1	1	1
Authorization Level	61	69	78	88	54
Estimated Outlays	46	73	81	93	59

The cost of this bill would fall in budget function 700.

Basis of Estimate

The following section-by-section cost analysis only addresses those sections of the bill that could be expected to have a significant budgetary impact.

Title I.

Section 101. This section would require the VA to provide outpatient care for certain category A veterans.

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
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Estimated Authorization Level	22	24	26	29	31
Estimated Outlays	22	24	26	29	31

This provision would not change any eligibility requirements for VA outpatient care. It would, however, make a sub-group of eligibles entitled to such care in VA facilities. According to the VA General Counsel's staff, the effect of this change would be that, in those few instances in which the VA cannot provide outpatient care because of insufficient resources, the agency would be required to expand resources to the extent necessary to provide the needed care. It was assumed that this would be accomplished by extending the hour of operation of over crowded outpatient clinics.

This estimate is based on data from the VA's 1986 survey of demand for medical care, which was conducted at all VA facilities, except Manila, from January 12 to January 31, 1986. The results of this survey indicate that between 1.4 percent and 0.3 percent of applicants for outpatient care are turned away because the facility does not have the resources to serve them. Based on routinely published statistics, it appears that virtually all of the turn-aways are concentrated in a few facilities in the sun belt.

The estimate assumes that section 101 would force the VA to expand resources sufficiently to accommodate additional outpatient visits equal to 2.0 percent of the number of outpatient visits projected under current law. A percentage increase greater than indicated by the survey data was used in the estimate in order to account for a return of some individuals who had stopped applying for care because of over crowding. An average cost per outpatient visit was projected by applying the consumer price index for medical services to the 1986 actual average cost per visit.

Section 108. This section would extend for three years the authority of the VA to provide adult day health care both in VA facilities and in non-VA facilities under contract.

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
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Estimated Authorization

Level	0	25	31	37	0
Estimated Outlays	0	25	31	37	0

In fiscal year 1986, the VA furnished adult day health care (ADHC) in nine VA facilities at a total cost of \$2.8 million. During 1987, ADHC programs were initiated in six more facilities. The estimate above assumes that the ADHC program will be expanded by four facilities in 1988 and by three facilities each year in 1989-1991. A real average cost per facility was derived based on 1986 experience; this was increased in the outyears for anticipated inflation.

According to the VA, the first contract for the provision of ADHC in a non-VA facility was approved on June 16, 1987. It is, therefore, difficult to estimate the size that the program could achieve by the end of 1991. The VA has authorized 16 medical centers to contract for ADHC services; but with delays in contract approvals, they estimate expenditures of less than \$1.5 million during the remainder of fiscal year 1987. Based on this data, it was estimated that around \$9 million would be spent in 1987 if all 16 medical centers had their programs in full operation.

This estimate assumes that 10 new medical centers would be authorized to contract for ADHC services in 1988 and five new centers in each year from 1989-1991. An average cost per facility was estimated based on the VA's projection for 1987. This figure was increased in future years for anticipated inflation.

Section 111. This section would require the VA to conduct a pilot program to provide treatment and rehabilitation in community-based treatment facilities to homeless veterans with chronic mental-illness disabilities. The pilot program would be authorized for one year only with an appropriation level of \$6 million.

	(By fiscal years, in millions of dollars)				
	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
Authorization Level	6	0	0	0	0
Estimated Outlays	4	2	0	0	0

The authorization level stated in the bill was assumed to outlay according to historical spending patterns for similar programs.

Title II.

Section 202. This section would authorize the payment of Saturday premium pay to VA nurses in those areas where it is needed for retention and recruitment.

	(By fiscal years, in millions of dollars)				
	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
Estimated Authorization					
Level	20	21	22	23	24
Estimated Outlays	20	21	22	23	24

According to VA staff, the agency would utilize Saturday premium pay to the same extent as Sunday premium pay is now used, thereby doubling the cost of premium pay. The above estimate represents a projection of the cost of Sunday premium pay based on historical trends.

Section 208. This provision would institute a system of "on-call" pay for VA health-care employees who are paid under the provisions of title 5 (U.S.C.), as a substitute for the current "stand-by" pay formula.

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
Estimated Authorization					
Level	-1	-1	-1	-1	-1
Estimated Outlays	-1	-1	-1	-1	-1

Under the stand-by pay system, an employee who works an average of 28 or more hours a week on stand-by in addition to his/her basic work week is paid basic pay plus 25 percent of basic pay, regardless of the number of stand-by and call-back hours actually worked in a given week. Under the proposed on-call system, an employee would be paid 10 percent of the hourly overtime rate for each hour actually spent on-call, plus the full overtime rate for each hour spent on call-back. In most cases, it is expected that costs would be lower under an on-call system, as well as being more closely tied to actual work hours involved. In addition, on-call pay-- unlike stand-by pay -- is not counted as basic pay for the Civil Service or Federal Employees Retirement Systems. Nor is on-call time subject to the requirements of the Fair Labor Standards Act. These two exemptions would both further reduce costs under an on-call system.

The actual cost of stand-by pay in fiscal year 1986 was \$5.8 million. According to VA estimates, on-call pay would cost approximately 74 percent of the cost of stand-by pay, or about \$4.3 million a year. There would be some small offsetting costs from a few facilities whose staffs are performing overtime stand-by duty on a voluntary basis, but this cost should be small.

Title III.

Section 302. This section would prohibit the VA from transferring any real property to other federal agencies unless the Congress specifically authorizes such a transfer in enacted legislation. Under current law, a federal agency declares a piece of property as "excess" if it is no longer

needed, and makes it available to other federal agencies, and then to the General Service Administration (GSA). GSA then may dispose of the "surplus" property, usually by sale.

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
Budget Authority	0	1	1	1	1
Estimated Outlays	0	1	1	1	1

Under current law, the VA must notify the Congress before declaring a piece of property as excess or making it available to other federal agencies. Once six months has elapsed after the notification, then the VA can proceed normally with the proposed action. Actual sale experience under current law indicates little activity with VA properties, despite the fact that the Office of Management and Budget has identified six properties, worth an estimated \$250 million, that it has directed the VA to declare as excess. Based on information from GSA, of 1,125 surplus properties sold for a total of about \$315 million over the past three years, only 7 of the properties, worth about \$3 million, have been VA properties. If this bill were to become law, VA properties that are not currently in the GSA inventory of surplus property could not be sold without Congressional approval. Based on the experience of recent years, CBO estimates that this requirement would result in a loss of about \$1 million in receipts each year beginning in 1989, relative to the CBO baseline.

Section 302 also would change the budgetary treatment of certain receipts from the sale of surplus properties. Currently, all proceeds from GSA's sale of surplus property are recorded as offsetting receipts and are deposited in the Land and Water Conservation Fund. This bill would require that any receipts from the sale of surplus VA property be deposited instead into a VA revolving fund in the Treasury for construction of parking garages. Although this provision would have no net effect on the budget, it would reduce the amounts credited to the Land and Water Conservation Fund, were the Congress to approve proposals to dispose of VA property.

Section 304. This section would exempt employees paid from the Canteen Service Revolving Fund from personnel ceilings applied to VA-wide employment levels.

It is estimated that this provision would not significantly affect the federal budget, because it was assumed that the VA-wide personnel ceiling would be reduced to reflect the exclusion of the canteen service employees. While the employment level of the canteen service may expand as a result

of this provision, they would be required to increase their receipts to offset any increase in operating costs.

Section 305. The intention of section 305 is to restore to the Canteen Service Revolving Fund the offsetting collections that were sequestered in fiscal year 1986 under the provisions of P.L. 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985. The General Counsel of CBO has concluded that the Secretary of the Treasury would not have the authority to restore these funds without a specific appropriation. The language of section 305 would, however, be sufficient to authorize such an appropriation.

The net impact of this provision on federal outlays would be negligible. The 1986 sequestration of funds from the Canteen Service Revolving Fund required the fund to transfer \$8,104,000 in unobligated balances to the Treasury. The restoration of these funds could increase the obligations of this stock revolving fund, but the increase would be offset by correspondingly higher collections.

Section 307. This section would direct the VA to build and operate an outpatient clinic in central or southern New Jersey.

(By fiscal years, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
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Estimated Authorization

Level	14	0	0	0	0
Estimated Outlays	0	1	2	4	4

It is not possible to estimate with any precision the cost of the proposed outpatient clinic until decisions have been made as to the size and location of the facility. The estimate above is based on the average cost of outpatient facilities currently under construction by the VA. However, the cost of facilities now underway varies considerably; thus, this estimate only reflects the general magnitude of potential cost. Furthermore, if the VA is required to purchase land on which to build the clinic, the cost would be significantly higher than shown. The estimate of outlays is based on historical spending patterns.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

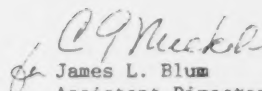
The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by enactment of this bill.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820).

10. ESTIMATE APPROVED BY:


 James L. Blum
 Assistant Director
 for Budget Analysis

AGENCY REPORTS

There follows excerpts from Veterans' Administration testimony at a hearing on May 20, 1987 in lieu of agency views:

MANDATORY ELIGIBILITY--OUTPATIENT CARE

Among the most far reaching of the proposals before the Committee is section 2 of the bill which would amend section 612 of title 38 first to expand the number of categories of veterans eligible for comprehensive outpatient care, and second, to mandate that VA provide outpatient care to those veterans. For the reasons discussed below we object to the enactment of section 2.

Current law provides that the Administrator may furnish needed outpatient care to any veteran for a service-connected disability, and to service-connected veterans rated at least 50 percent disabled for any disability. Essentially comprehensive outpatient care may also be furnished to veterans of World War I or earlier wars, to certain profoundly disabled VA pensioners, and to former prisoners of war. Other veterans are eligible for outpatient care only if it is needed to prepare them for hospital care, to obviate the need for hospital care, or if the care is required as a followup to a period of inpatient care. Current law generally limits such followup outpatient care to a twelve-month period.

Section 2 of the bill would expand eligibility for essentially comprehensive outpatient care to all veterans for whom VA has an obligation to furnish hospital care, the so-called "category A" veterans.

Major additional categories of veterans who would be made eligible for open-ended outpatient care for any disability would be all service-connected veterans regardless of their disability rating, and all lower income nonservice-connected veterans, those with annual incomes below \$15,195 if single. In our view, existing outpatient care eligibility is consistent with the VA's principal mission. Congress has long required VA in providing ambulatory care to give highest priority to care of veterans' service-connected conditions, and second priority to the very severely disabled service-connected veterans (those rated at least 50%). Congress has also assigned priorities (in section 612(i) of title 38, U.S. Code) to the treatment of other service-connected veterans, former prisoners of war, and certain other veterans. To the extent that VA can meet the needs of those veterans assigned a statutory priority, VA also provides outpatient care to many other veterans, consistent with current law.

This bill would fundamentally alter the VA's role, however, directing that outpatient care be provided to the entire spectrum of lower income veterans whose disabilities have no relationship to their service, and without regard to the severity of their medical needs. Furthermore, a major revision of eligibility for VA medical care has only recently occurred (P.L. 99-272). Implementation of this revision was initiated on July 1, 1986. Full assessment of the impact of this revision is therefore not yet possible. An assessment of probable cost and the extent to which outpatient care provided is actually meeting the needs of eligible veterans should be made prior to further legislative revision of eligibility.

We therefore recommend that the proposed legislation not be enacted.

DOMICILIARY CARE

Section 3 of the draft bill would amend the eligibility provisions for VA domiciliary care. It would establish a veteran's inability to defray the expenses of needed domiciliary care as a single criterion of eligibility. We support this provision.

Under existing domiciliary care eligibility provisions, the law appears to impose more stringent requirements on the service-connected veteran than on other veterans. Thus, to be eligible for domiciliary care, the service-connected veteran must have a permanent disability, tuberculosis, or a neuropsychiatric ailment; be incapacitated from earning a living; and have no adequate means of support. In contrast, statutory provisions governing domiciliary eligibility for other veterans impose none of these requirements, and condition eligibility on an "inability to defray" and a need for such care. Under existing regulations, however, eligibility for domiciliary care generally requires that a veteran be incapacitated from earning a living and have no adequate means of support. The requirement that a veteran have no adequate means of support as a condition of eligibility for domiciliary care is considered to mean in general that the applicant has an income of less than \$415 per month. We would anticipate that if this provision is enacted implementing regulations would continue in effect such income limits.

PAY SCALES FOR DEPARTMENT OF MEDICINE AND SURGERY

Section 4 of the draft bill would revise the pay schedules in section 4107 of title 38 for senior Central Office DM&S employees appointed under section 4103 of title 38 and for physicians, dentists, nurses, clinical podiatrists, and optometrists appointed under section 4104(1). These revisions would update these pay schedules to conform with the current pay rates increased by Executive Order 12578 of December 31, 1986. We favor this provision.

We would recommend that the ceiling on the base pay for the position of Associate Deputy Chief Medical Director (ADCMD) be raised from Executive Level V to Executive Level IV, making it equal to the ceiling on pay of the Deputy Chief Medical Director. While it is unusual to place the salary of a subordinate on a par with that of the individual's supervisor, this change merely reflects the unique managerial roles expected of ADCMDs, who are charged with the responsibility of administering a vast and complex medical care system. The rate increase is in recognition of the singular leadership qualities and resourcefulness demanded of an ADCMD.

The changes in the pay schedules recommended by your bill, and raising the ADCMD grade level, are contained in the VA's own legislative proposal to reorganize the Office of the Chief Medical Director. We appreciate, Mr. Chairman, your introducing our proposal as H.R. 2010. We will discuss the other major features of H.R. 2010 toward the end of this statement, along with our other legislative proposals.

SATURDAY PREMIUM PAY FOR REGISTERED NURSES

Section 5(a) of the draft bill would require VA to provide premium pay to registered nurses for Saturday duty. Currently, section 4107(e)(3) of title 38 requires VA to pay a registered nurse additional pay up to 25 percent of the nurse's hourly rate of basic pay for duty on Sunday.

VA has authority to provide premium pay to nurses for Saturday duty under section 4107(e)(10) and is now exercising this authority based on need. We believe that this existing authority is not only more flexible than proposed by the bill, but it can be directed specifically to meeting the main purpose of premium pay--to recruit and retain nurses for VA. A Department Task Force charged with studying recruitment and retention problems has identified expanded-use of this premium-pay authority as one element of part of a possible long-term solution to these problems.

Therefore, we oppose this provision not only because VA already has a more flexible premium-pay authority, but also because of the associated high costs of mandating such premium pay throughout the Department. Presuming that the Saturday premium pay would be equal to that paid for Sunday premium pay, we estimate that the cost of this provision to be \$21 million for Fiscal Year 1989 and a five-year cost estimate of \$115 million.

APPOINTMENT OF PHARMACISTS UNDER TITLE 38

Section 5(b) of the draft bill would allow VA to hire and pay registered pharmacists under the title 38 personnel system, while other employment matters concerning pharmacists, such as performance appraisal, leave, hours of duty, adverse action, and probationary periods, would continue to be governed under the provisions of title 5.

The main objective of this provision is to assist VA in recruiting and retaining pharmacists. However, because we do not believe that this provision will significantly achieve this objective, we do not favor its enactment. This provision is similar to provisions of Public Law 98-160, which authorized appointment and pay under title 38 of respiratory therapists, physical therapists, and licensed practical/vocational nurses. At the time this legislation was passed, the Administration expressed concern that the special personnel authorities were unnecessary and costly and singled out VA for special treatment. It is our experience that the change in appointment authority of these professions did not significantly enhance recruitment and retention, except with respect to respiratory therapists.

The only practical advantage we find to this provision is granting VA authority to approve special rates for pharmacists without the requirement for review by the Office of Personnel Management before the rates become effective. Based on our experience with Public Law 98-160, we estimate that this provision would result in a six- to eight-week reduction in the time required to process special rate requests. We do not see how this advantage is sufficient to justify this provision.

DISCIPLINARY BOARDS FOR MEDICAL PERSONNEL

Section 6 of the draft bill would limit the appointment of disciplinary boards for employees appointed under section 4104(1) of title 38. Under this provision, VA could simplify disciplinary procedures affecting these employees in cases where the proposed penalties are relatively light. VA supports the proposal, but would favor augmenting the bill to include authority for delegating both the power to appoint disciplinary boards and to act on disciplinary board recommendations as contained in our bill, H.R. 2009, which you have introduced at our request.

Currently section 4110 of title 38 mandates a rather cumbersome peer review process for disciplinary actions against non-probationary physicians, dentists, podiatrists, optometrists, nurses, physician assistants and expanded-function dental auxiliaries, for reasons of inaptitude, inefficiency, or misconduct. There is no distinction based on seriousness of offenses. Current procedures involve notice of charges, opportunity for a pre-decision hearing, right to legal representation and post-decision appeal for the least serious cases, such as a three-day suspension for a minor offense, such as well as for the most serious offense, such as removal for patient abuse. The hearing, required at the request of the employee, is a trial-type adversarial hearing of which a verbatim transcript is taken.

The current disciplinary board system has proven to be overly centralized, time-consuming and highly legalistic, with an average case taking between nine and fourteen months to complete. As the volume of disciplinary actions increases, further processing delays are incurred. The effect of the complexity of the current disciplinary board system has been to diminish the use and usefulness of disciplinary actions as a behavior-modifying measure to maintain high standards of patient care in the medical centers. Because the current system uses such large amounts of time and resources, it discourages managers from proposing moderate penalties and thus tends to frustrate the progressive discipline approach.

The draft bill would limit the use of the disciplinary board machinery to cases where the proposed penalties are most serious: removal, suspension of more than 14 days, or demotions involving loss of grade or basic pay. All lesser disciplinary actions would be excluded. Administrative appeal or grievance procedures would be established for these latter actions under regulations prescribed by the Administrator pursuant to current authority. As a result, the volume of section 4110 disciplinary actions would be reduced. Further, lesser disciplinary actions would be less costly and cumbersome and therefore more readily invoked so that progressive discipline would be more feasible.

We strongly believe any change to the disciplinary board process should clearly enable those cases that remain covered by section 4110 to be more expeditiously resolved, by giving VA the express power to delegate authority to appoint boards and act on board recommendations. The current bill, while providing for regulations to govern appointing boards, also repeals the current explicit authority to delegate both board appointments and review of board recommendations. Thus, the bill would require the involvement of the Administrator in the appointment and review process of each and every boardcase. Therefore, it would not go far enough to solve the problems in the current system.

On the other hand, the VA bill, H.R. 2009, would change the current system by expressly authorizing the Chief Medical Director to delegate the current board-appointing authority and by expressly empowering the Chief Medical Director to redelegate the authority currently delegated to him by the Administrator to act upon recommendations of the board. In addition, the current bill would appear to reach conduct only in connection with duty. It should be amended to authorize boards to hear issues involving off duty misconduct as well.

Decentralizing the disciplinary board process would expedite board results and thus better serve the affected employee's interest in getting a timely result.

We believe this provision would result in some limited cost savings through reduced expenses for processing disciplinary actions although the major benefits would be a more responsive and timely disciplinary system.

COURSES OF TRAINING FOR HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

Section 7 of the draft bill would provide VA with more flexibility to grant scholarships under the VA Health Professions Scholarship Program by extending eligibility for these scholarships to all employees covered under section 4104 of title 38.

Currently, eligibility for these scholarships is limited to individuals accepted for enrollment, or enrolled, as a student in a course of training leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing, or to become a physician assistant or expanded-function dental auxiliary. Section 7 would extend eligibility to include those seeking degrees for other health-care professions, such as pharmacists, psychologists, dietitians, occupational and licensed physical therapists, and licensed practical or vocational nurses.

The scholarship program has proven to be a highly successful method for recruiting and retaining health care professionals for VA. Participants receiving these scholarships are obligated to work for VA upon completion of their training. The majority of those participants who finish their period of obligation remain with VA afterwards.

The current program does not provide VA the flexibility to grant scholarships to meet recruitment needs as shortages develop in other health-care professions, such as physical therapists, for which there currently is a shortage in VA.

We therefore favor the Committee's proposal, which would assist VA in diminishing the adverse effects of future shortages for those health-care occupations we employ under title 38. If enacted, VA would expend an additional \$1 million in fiscal year 1988 for scholarships for physical therapists, which is already contemplated in the President's 1988 budget.

We would also recommend that section 4144 of title 38 provide that individuals in the professions being made eligible for the Scholarship Program under this bill be also liable for the same penalties as are now prescribed for those currently eligible for the Program.

PERSONNEL CEILINGS - RESEARCH

Section 8 of the bill would exclude temporary research personnel employed by the VA for any personnel ceiling on full-time equivalent employees, or from any other personnel ceiling applicable to VA employees. Temporary research personnel are defined in the section as non-career VA employees working on a

research activity, and who are paid with funds appropriated for research, or with non-VA funds, such as a grant from a private entity to fund a joint VA/private research project.

This provision would address an issue VA has faced in our research program. In our view, however, it has become apparent that the issue does not require a legislative solution. Rather, in those instances where research initiatives would be frustrated because of a personnel ceiling, the ceiling can be adjusted administratively on a case by case basis.

We are looking further into the program and hope to see what experience other agencies have had in dealing with it.

PILOT PROGRAM--HOSPITAL MANAGEMENT EFFICIENCY

Section 9 of the draft bill would provide VA authority to conduct a pilot program under which we could explore the feasibility of operating VA medical centers free of certain statutory and regulatory constraints which the Administrator determines are appropriate for waiver. We believe such a pilot effort could lead to improvements in the efficiency and effectiveness of our medical centers, and we favor the enactment of such authority.

Specifically, the measure would call for VA to designate five medical centers at which each center's director, pursuant to the Administrator's authorization, could waive or alter any laws and regulations applicable to the center's management and administration to determine the effect of such waivers or alterations on the efficiency and economy of the center. This pilot effort at achieving management efficiency would be authorized to operate through September 30, 1990.

We view this concept as offering an important opportunity to explore mechanisms for increasing the timeliness and cost efficiency of our service delivery systems, and we welcome it. We anticipate that by selectively removing constraints in such areas as fiscal, personnel, and procurement administration, we can evaluate whether this will enable our managers to achieve efficiencies and economies without diminishing the integrity of our operations.

While we support adoption of this proposal, we do however recommend a number of changes. Thus, instead of providing, for example, that the medical center director may waive laws and regulations (pursuant to the Administrator's authorization), we believe that the Administrator, with the concurrence of the Agency whose laws are being effected, should be the exclusive official vested with such authority, and that the bill should permit him to authorize the directors of the "test" facilities to operate their respective facilities without regard to those laws and regulations which he has waived. In addition, we would suggest that you clarify the meaning of the provision authorizing not simply the waiver of a law's application but also authorizing officials to "alter such laws." We are uncertain as to the scope of that authority. For example, one could construe that phrase, as drafted, as authorizing the directors, notwithstanding limitations in law on the availability of medical care monies, to retain until September 30, 1990, such monies as might be allocated. While such authority would be desirable within the framework of the pilot program, it is not clear whether such an "alteration" of law is contemplated.

As a final point, we note that the draft bill would vest the Administrator with very broad authority to waive virtually any law relating to the operations of a medical center. We would not contemplate sweeping waivers of statutes. Thus, we do not intend to waive fundamental civil service and procurement laws, for example, or to alter basic patient care eligibility and priority of care provisions. Additionally, subject to a few limited exceptions, our "test" medical centers would also remain subject to established principles of appropriations law. With enactment of the draft bill, we would anticipate that, through the exercise of limited waivers, the pilot program would include the following:

--Lifting of specific funding constraints on when, and for what, the test facilities may obligate the allotted funds which they receive from the Medical Care appropriations.

--Authorization for the test facilities to carry over to the next fiscal year unobligated portions of their annual

allotments from the Medical Care appropriation for the duration of the pilot program.

--Lifting of employee travel funding restrictions, and

--Suspending mandatory participation of test facilities in A-76 studies, and waiver of section 5010(c) of title 38, U.S. Code regarding so-called "contracting out."

In general, lifting what, for test purposes, may be considered restrictive constraints in such areas as fiscal, personnel, and procurement administration, should enable our managers to achieve substantial efficiencies and provide better service.

HOMELESS VETERANS

Public Law 100-6 provided, in pertinent part, for the transfer to the Veterans Administration medical care account of some \$5 million out of funds previously appropriated for Fiscal Year 1987, to be available to carry out the new contract authority granted the Administrator in that law (codified at section 620C of title 38, U.S. Code). VA is currently developing contract arrangements under that authority to furnish community-based residential treatment to chronically mentally ill homeless veterans. Public Law 100-6 set a \$5 million spending limit on the use of this new authority. Section 10 of the bill would repeal section 620C and authorize a one-year pilot program to provide community-based residential care to homeless chronically mentally ill veterans. This measure would authorize appropriations of \$6 million in FY 88 for the program. The bill would limit funding for the program to monies specifically appropriated for that purpose and would require that not less than \$.5 million of such appropriation would be devoted to management and monitoring of the program.

Under current plans, projects at some 43 VA medical facilities have been identified for funding. Contracting with appropriate community based organizations should begin shortly. Outreach teams will identify eligible homeless veterans living in shelters and on the streets, and attempt to bring them into our medical centers where they will receive complete medical and psychiatric evaluations. When indicated some of these veterans will be placed by mutual agreement into community-based contracted therapeutic residential settings where they can receive services to help them become reintegrated into society. A system is also being set up to gather data to ensure the quality and extent of service delivery and to assess the overall effectiveness of the new programs.

Mr. Chairman, we have high hopes for the success of this program. We look forward to our initial evaluation of its impact on this target population.

BENEFICIARY TRAVEL

H.R. 2327 would amend the statutory authority for VA to furnish veterans with travel to and from a VA facility in connection with receipt of benefits, principally health care care benefits.

As you are aware, VA recently published regulations which significantly limited its beneficiary travel program. This bill would appear, in essence, to require that VA reinstitute beneficiary travel payments for modes of travel which were limited under those VA regulations. We strongly oppose this bill for the reasons I will discuss.

The bill would first change section 111(a) of title 38, United States Code, to provide that the Administrator "shall" rather than "may" pay for the necessary expense of travel of an "eligible claimant or beneficiary." It would add a new subsection specifying the individuals "entitled" to beneficiary travel payments. Included are veterans seeking care for a service connected disability; veterans with a service connected disability rated at least 50 percent; veterans in receipt of VA pension or whose income does not exceed the VA pension amount; veterans requiring, but unable to pay for a special mode of transportation such as an ambulance; veterans unable to defray the expenses of the travel as determined by the Administrator; and any other persons the Administrator determines, in accordance with regulation, should receive payment for travel. The bill would provide that travel may be paid for the purposes specified in the VA's regulations prior to their recent amendment,

and it would continue the statutory prohibition against payment of travel in excess of the cost of reasonably accessible public transportation, or in excess of that incurred by the beneficiary.

The VA's recently published regulations, which limited routine beneficiary travel payments, were the culmination of several years of effort to administratively control rapidly escalating expenditures for this travel. The basis for these efforts was the belief that routine, nonemergent travel payments could be scaled back without effectively denying veterans access to needed care, and that such funds could be more effectively devoted to providing direct health care for our veterans. In our view, the current regulations strike a fair balance, and accommodate many of the concerns of those who questioned the proposed change. The regulations continue to authorize VA to pay for all travel of veterans requiring a special mode of transportation to the hospital, such as an ambulance. To minimize the hardship on veterans living a great distance from a VA facility, the regulations provide that VA will pay for transportation costs in excess of a deductible amounting to \$11.00. There are also other alternatives for delivering services to veterans which work to minimize the impact of travel costs, including contract hospitalization, fee basis outpatient care and outreach programs. Considering the strong basis for the regulatory changes, we oppose H.R. 2327 which would mandate a return to a system similar to that which existed prior to those changes. We believe the beneficiary travel program as it now exists after publication of the regulations should be left in place so it can be determined whether it meets the essential needs of veterans seeking VA health care benefits.

We estimate that the enactment and implementation of this measure would increase beneficiary travel payments by some \$55.5 million annually over and above the costs we anticipate incurring under our regulations. Thus, we anticipate incurring total costs under the beneficiary travel program of \$110 million in FY 88 and five-year costs of some \$633 million. If this measure were to be effective during this fiscal year, additional costs in the range of \$5 million/month could be expected.

READJUSTMENT COUNSELING PROGRAM

Mr. Chairman, you also requested that we present views on H.R. 2146, a bill which would postpone for one year the date by which the VA's Readjustment Counseling Program would have to be changed from a program taking place primarily in vet centers to a program taking place primarily in VA medical centers. Specifically the bill would amend section 612A(g) to postpone the transition date from October 1, 1989, to October 1, 1990. It would also amend that section to postpone for one year the dates by which the Administrator must submit various reports to the Veterans' Affairs committees of Congress regarding that change. Specifically, the bill would postpone the April 1, 1987, due date for a report in which the Administrator must evaluate and report on the effectiveness of the Readjustment Counseling Program in meeting the readjustment needs of Vietnam veterans, the extent to which readjustment needs of such veterans remain unmet, and the extent to which Vet Centers are required to meet this unmet need. The bill would also postpone the due date of a report presently due July 1, 1987, describing VA's plan for the transition of the Readjustment Counseling Program to one providing services primarily through VA medical centers, and a report presently due February 1, 1989, on VA's experience during the first year of the transition. Finally, the bill would require that the Administrator maintain and operate until October 1, 1988, the same number of vet centers that were in operation on April 1, 1987.

Mr. Chairman, we have no objection to postponing the transition date for the readjustment counseling program by one year. We strongly object, however, to the provision in this bill which would require that we continue to operate on a free standing basis, all of the Vet Centers in operation on April 1, 1987. As you are aware, VA is planning on relocating some nine Vet Centers to VA medical centers this fiscal year. This bill apparently seeks to rule out that action. Considering the fact that existing law (as well as this proposal) continue to require VA to relocate a majority of the Vet Centers in the near future, we believe it would be wise to proceed with this small-scale relocation. That will allow the Agency to gain experience and information which will be useful in planning the full transition required by law. Moreover, relocation of the specific centers was a deliberate initiative based on sound criteria. In selecting the Vet Center to be relocated, we considered

such factors as the distribution of Vietnam era veterans by census, the distance between the vet center and the VA medical facility. This was not arbitrary decisionmaking, but a well-conceived, practical effort to assure continued effective service delivery. We do not believe the interests of this program or its clients would be well served by statutorily freezing it in a particular configuration. Accordingly, we strongly urge that you not adopt this aspect of H.R. 2146.

MAJOR VA LEGISLATIVE PROPOSALS

As I indicated in my opening remarks, we are grateful that you have introduced draft legislation which we submitted to Congress this session. We welcome your active consideration of these measures. They include bills which would foster many of the goals this Committee stands for--providing VA the means to improve our health-care system, enabling it to administer health care more effectively, and to establish the most efficient management structures possible for that system.

Let me briefly highlight some of the measures we have initiated:

-H.R. 2001 would extend the agency's authority to provide adult day health care services, which will otherwise expire on September 30, 1988. We see this program as providing a very promising alternative to institutionalization.

-H.R. 2002 would solve a series of problems in ensuring that certain title 5 health-care personnel, such as x-ray, laboratory, operating room and other technologists and technicians are available in medical emergencies or for unforeseen medical needs that occur outside their regular duty hours by authorizing the Administrator to pay "on call" pay to civil service health care personnel in the same manner that this pay is provided to title 38 registered nurses. Under this bill, VA could schedule these health-care personnel "on call" as necessary without instituting costly standby pay.

-H.R. 2003 would promote VA's medical research and education programs by providing the Chief Medical Director with additional flexibility to appoint nonlicensed practical or vocational nurses, physical therapists and registered nurses to research or academic assignments. The waiver authority embodied in the draft bill is not intended for, and would not be used in connection with, any person who would have any responsibility for any patient. The draft bill would also assist the VA outpatient clinic in Manila to provide quality health-care to veterans by permitting the appointment of temporary full or part-time practical or vocational nurses or physical therapists who are licensed only in the Philippines to serve in that facility.

-H.R. 2004 would clarify the authority of the Chief Medical Director or designee to accept, reject, or modify recommendations made by Professional Standards Boards as a result of their reviews of the performance of probationary medical professionals. Currently, the Chief Medical Director, who is the official responsible for the operation of the Department of Medicine and Surgery, plays no substantive role in this review process. This provision would clarify the intent of Congress that the Administrator has the power to prescribe by regulation both the procedures to be followed by the Board and the circumstances in which Board proceedings may be initiated and that final action in the review process should be taken by the Chief Medical Director. Also, this provision would authorize these Boards to recommend corrective action other than the requirement in section 4106 that an employee be removed for unsatisfactory performance. This proposal would provide flexibility to allow the reviewing body to tailor its recommendations to fit the particular circumstances of each case.

-H.R. 2006, entitled the "Veterans' Health Care Benefits Administration Act of 1987," would, through a series of amendments, remove statutory impediments that block access to VA care and help improve administration of VA medical programs. Among its provisions is a measure that would permit foreign nationals who were disabled while serving as members of U.S. armed forces to obtain VA-sponsored health care for those disabilities without regard to citizenship.

H.R. 2006 would also provide needed authority to arrange for emergency hospital care needed by veterans who have been undergoing community nursing home care at VA expense.

-H.R. 2007, entitled the "VA Health Care Amendments Act of 1987," would, for example, clear up a troublesome issue surrounding the definition of the term "nursing home care" to provide that that term includes both skilled and intermediate levels of care.

-H.R. 2010 would amend section 4103 of title 38, United States Code, to add flexibility in staffing the office of the Chief Medical Director (CMD). The provision would increase to two the number of authorized Associate Deputy Chief Medical Directors (ADCMD), and would broaden the categories of individuals who could serve in either of the two positions to include highly qualified nonphysicians with health-care management and hospital management backgrounds and skills. The number of authorized ACMD's would be reduced from eight to seven, partly because of the addition of the second ADCMD position. H.R. 2010 would also make discretionary much of the rigid structure now set forth in section 4103 by eliminating the requirement that specific Service Directors exist in the Office of Chief Medical Director. All of the changes in this bill would enhance the flexibility of the Chief Medical Director to organize the operation of the office in the way that best supports the needs of the Department's mission.

Mr. Chairman, this concludes our testimony. My colleagues and I would be pleased to respond to any questions you may have.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

PART I—GENERAL PROVISIONS

* * * * *

CHAPTER 1—GENERAL

* * * * *

§ 101. Definitions

For the purposes of this title—

(1) The term "Administrator" means the Administrator of Veterans' Affairs.

* * * * *

(28) The term "nursing home care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require [skilled nursing care] *nursing* and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. [The term includes intensive care where the nursing service is under the supervision of a registered professional nurse.] *Such term includes services delivered in skilled, intermediate care, and combined facilities. It does not include domiciliary or residential care.*

CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

* * * * *

SUBCHAPTER II—ADMINISTRATOR OF VETERANS' AFFAIRS

210. Appointment and general authority of Administrator; Deputy Administrator.

* * * * *

223. *Administrative settlement of tort claims.*

* * * * *

Subchapter II—Administrator of Veterans' Affairs

* * * * *

§ 223. *Administrative settlement of tort claims*

(a) *Notwithstanding the limitations in section 2672 of title 28, the Administrator may settle any claim for money damages against the United States cognizable under section 1346(b) or 2672 of title 28 or section 4116 of this title to the extent the authority to do so is dele-*

gated to the Administrator by the Attorney General. Such delegation may not exceed the authority delegated by the Attorney General to United States attorneys to settle claims for money damages against the United States.

(b) For purposes of this subsection, the term "settle", with respect to a claim, means consider, ascertain, adjust, determine, and dispose of the claim, whether by full or partial allowance or by disallowance.

* * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home, and domiciliary care.

* * * * *

[620C. Community-based psychiatric residential treatment of chronically mentally ill veterans.]

* * * * *

Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

(1) * * *

* * * * *

(4) The term "Veterans' Administration facilities" means—

(A) facilities over which the Administrator has direct jurisdiction; [and]

(B) Government facilities for which the Administrator contracts[.]; and

(C) public or private facilities at which the Administrator provides recreational activities for patients receiving care under section 610 of this title.

* * * * *

§ 223. Administrative settlement of tort claims

(a) Notwithstanding the limitations in section 2672 of title 28, the Administrator may settle any claim for money damages against the United States cognizable under section 1346(b) or 2672 of title 28 or section 4116 of this title to the extent the authority to do so is delegated to the Administrator by the Attorney General. Such delegation may not exceed the authority delegated by the Attorney General to United States attorneys to settle claims for money damages against the United States.

(b) For purposes of this subsection, the term "settle", with respect to a claim, means consider, ascertain, adjust, determine, and dis-

pose of the claim, whether by full or partial allowance or by disallowance.

* * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home, and domiciliary care.

* * * * *

[620C. Community-based psychiatric residential treatment of chronically mentally ill veterans.]

* * * * *

Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

(1) * * *

- * * * * *
- (4) The term “Veterans’ Administration facilities” means—
- (A) facilities over which the Administrator has direct jurisdiction; **[and]**
 - (B) Government facilities for which the Administrator contracts **[.]**; and
 - (C) *public or private facilities at which the Administrator provides recreational activities for patients receiving care under section 610 of this title.*
- * * * * *

§ 603. Contracts for hospital care and medical services in non-Veterans’ Administration facilities

(a) When Veterans’ Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Administrator, as authorized in section 610 or 612 of this title, may contract with non-Veterans’ Administration facilities in order to furnish—

(1) * * *

- (2) medical services for the treatment of any disability of—
- (A) a veteran described in section 612(a)(1)(B) of this title;
 - (B) a veteran described in section **[612(f)(1)(A)(ii)] 612(f)(1)(C)(iii)** of this title; or
- * * * * *

- (3) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Veterans’ Administration facility or receiving nursing home care in a

public or private nursing home in the community under section 620 of this title until such time following the furnishing of care in the non-Veterans' Administration facility as the veterans can be safely transferred to a Veterans' Administration facility;

* * * * *

(6) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Veterans' Administration out-patient clinics to obviate the need for hospital admission; **[or]**

(7) outpatient dental services and treatment, and related dental appliances, for a veteran described in section 612(b)(1)(G) of this title **[.]**; and

(8) *hospitalization of a person for observation and examination to determine eligibility for a benefit under a program administered by the Veterans' Administration.*

* * * * *

Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domiciliary care

(a) * * *

(b) The Administrator, within the limits of Veterans' Administration facilities, may furnish **[domiciliary care to—**

[(1) a veteran who was discharged or released from the active military, naval, or air service for disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and

[(2) a veteran *domiciliary care to a veteran* who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care.

* * * * *

§ 612. Eligibility for medical treatment

(a)(1) Except as provided in subsection (b) of this section, the Administrator **[may]** *shall* furnish medical services as the Administrator determines are needed—

(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service); **[and]**

(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more **[.]**; and

(C) to any person (i) for a disability for which the person is in receipt of compensation under section 351 of this title, or (ii) for a disability for which the person would be entitled to compensation under section 351 of this title but for a suspension pursu-

ant to that section, but only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in such section.

* * * * *

[(f)(1) Except as provided in paragraph (4) of this subsection, the administrator may furnish medical services for any disability on an outpatient or ambulatory basis—

[(A) to any veterans eligible for hospital care under section 610 of this title (i) if such services are reasonably necessary in preparation for, or (to the extent that facilities are available) to obviate the need of, hospital admission, or (ii) if such a veteran has been furnished hospital care, nursing home care, or domiciliary care and such medical services are reasonably necessary to complete treatment incident to such care (for a period not in excess of twelve months after discharge from such treatment, except where the Administrator finds that a longer period is required by virtue of the disability being treated); and

[(B) to any veteran who is a former prisoner of war.]

(f)(1)(A) *In addition to the medical services provided under subsection (a) of this section, the Administrator shall furnish medical services on an outpatient or ambulatory basis—*

(i) to any veteran who is a former prisoner of war, for any disability; and

(ii) to any other veteran eligible for hospital care under section 610(a)(1) of this title, for any purpose described in subparagraph (C) of this paragraph.

(B) *Subject to paragraph (4) of this subsection, the Administrator may furnish medical services on an outpatient or ambulatory basis to a veteran eligible for hospital care under section 610 of this title (other than under section 610(a)(1)) for any purpose described in subparagraph (C) of this paragraph.*

(C) *Medical services described in this subparagraph are medical services reasonably necessary—*

(i) in preparation for hospital admission;

(ii) to obviate the need of hospital admission, but in the case of a veteran described in subparagraph (B) of this paragraph, only to the extent that facilities are available; and

(iii) in the case of a veteran who has been furnished hospital care, nursing home care, or domiciliary care, to complete treatment incident to such care, but only for a period not in excess of 12 months after discharge from such care, unless the Administrator finds that a longer period is required by reason of the disability being treated.

* * * * *

§ 612A. Eligibility for readjustment counseling and related mental health services

(a) * * *

* * * * *

(g)(1) During the 24-month period ending on September 30, 1989, the Administrator [shall] *may* take appropriate steps to ensure—

(A) * * *

* * * * *

§ 620. Transfers for nursing home care; adult day health care

(a) * * *

* * * * *

(f)(1)(A) The Administrator is authorized to furnish adult day health care as provided for in this subsection. For the purpose only of authorizing the furnishing of such care and specifying the terms and conditions under which it may be furnished to veterans needing such care—

* * * * *

(3) Adult day health care may not be furnished under this section after September 30, [1988.] 1991.

* * * * *

§ 620C. Community-based psychiatric residential treatment for chronically mentally ill veterans

[(a) For the purpose of this section:

[(1) The term “case management” includes the coordination and facilitation of all services furnished to a veteran by the Veterans’ Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by either the Veterans’ Administration or another entity), monitoring, reassessment, and followup.

[(2) The term “contract facility” means any facility which has been awarded a contract under subsection (b)(1) of this section.

[(3) The term “eligible veteran” means a veteran who, at the time of referral to a contract facility—

[(A) is being furnished hospital, domiciliary, or nursing home care by the Administrator for a chronic mental illness disability; or

[(B) is homeless and has a chronic mental illness disability; or

[(C) is a veteran described in section 612(a)(1)(B) of this title and has a chronic mental illness disability.

[(b)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from chronic mental illness disabilities.

[(2) Before furnishing such care and services to any veteran through a contract facility, the Administrator shall approve (in accordance with criteria which the Administrator shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

[(c) In the case of each eligible veteran provided care and services under this section, the Administrator shall designate a Veterans' Administration health-care employee to provide case management services.

[(d) In furnishing care and services under this section, the Administrator shall accord priority for such care and services in the following order:

[(1) To any veteran for a service-connected chronic mental illness disability.

[(2) To any veteran with a disability rated as service-connected.

[(3) To any veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 622(a)(1) of this title.

[(e) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a contract facility under this section. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the contract facility. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Veterans' Administration facility that provided the assistance.

[(f) Not later than 3 years after the date of enactment of this section, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under this section. The report shall include the Administrator's evaluation and findings regarding—

[(1) the quality of care furnished to participating veterans through contract facilities;

[(2) any health advantages that may result from furnishing such care and services to veterans in such contract facilities rather than in inpatient facilities over which the Administrator has direct jurisdiction;

[(3) the effectiveness of the use of contract facilities under this section is enabling the participating veterans to live outside of Veterans' Administration inpatient facilities and to achieve independence in living and functioning in their communities;

[(4) the health advantages and cost effectiveness of the use of contract facilities under this section to furnish shelter and health care to homeless veterans who are suffering from chronic mental illness disabilities;

[(5) the cost-effectiveness of furnishing such care through contract facilities under this section, including the effect on the average daily census in the Veterans' Administration hospitals, nursing homes, and domiciliary facilities participating in the program (taking into account whether the beds previous-

ly occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied) and the effect on the numbers of Veterans' Administration staff employed at such facilities; and

[(6) any plans for administrative action, and any recommendations for legislation, that the Administrator considers appropriate to include in such report.]

* * * * *

[(1) To any veteran for a service-connected chronic mental illness disability.

[(2) To any veteran with a disability rated as service-connected.

[(3) To any veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 622(a)(1) of this title.

[(e) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a contract facility under this section. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the contract facility. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be creditable to funds allotted to the Veterans' Administration facility that provided the assistance.

[(f) Not later than 3 years after the date of enactment of this section, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under this section. The report shall include the Administrator's evaluation and findings regarding—

[(1) the quality of care furnished to participating veterans through contract facilities;

[(2) any health advantages that may result from furnishing such care and services to veterans in such contract facilities rather than in inpatient facilities over which the Administrator has direct jurisdiction;

[(3) the effectiveness of the use of contract facilities under this section in enabling the participating veterans to live outside of Veterans' Administration inpatient facilities and to achieve independence in living and functioning in their communities;

[(4) the health advantages and cost effectiveness of the use of contract facilities under this section to furnish shelter and health care to homeless veterans who are suffering from chronic mental illness disabilities;

[(5) the cost-effectiveness of furnishing such care through contract facilities under this section, including the effect on the average daily census in the Veterans' Administration hos-

pitals, nursing homes, and domiciliary facilities participating in the program (taking into account whether the beds previously occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied) and the effect on the numbers of Veterans' Administration staff employed at such facilities; and

[(6) any plans for administrative action, and any recommendations for legislation, that the Administrator considers appropriate to include in such report.]

* * * *

§ 624. Hospital care, medical services, and nursing home care abroad.

(a) * * *

(b) The Administrator may furnish necessary hospital care and medical services to any otherwise eligible veteran for any service-connected disability [if the veteran (1) is a citizen of the United States sojourning or residing abroad, or (2) is in the Republic of the Philippines.] if the veteran—

(1) *is a citizen of the United States sojourning or residing abroad;*

(2) *is in the Republic of the Philippines; or*

(3) *is sojourning or residing in Canada.*

* * * *

§ 629. Recovery by the United States of the cost of certain care and services

(a) * * *

(b)(1) As to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

(2)(A) * * *

* * * *

(c) *A proceeding under subparagraph (B) of this paragraph may not be brought after the end of the six-year period beginning on the last day on which care or services for which recovery is sought are furnished to the veteran by the administrator under this chapter.*

* * * *

CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

* * * *

Subchapter I—Organization; General

* * * *

§ 4103. Office of the Chief Medical Director

(a) The Office of the Chief Medical Director shall consist of the following—

(1) * * *

* * * * *

[(3) The Associate Deputy Chief Medical Director, who shall be an assistant to the Chief Medical Director and the Deputy Chief Medical Director, and who shall be a qualified doctor of medicine, appointed by the Administrator upon the recommendation of the Chief Medical Director.]

(3) Two Associate Deputy Chief Medical Directors, who shall be assistants to the Chief Medical Director and the Deputy Chief Medical Director, appointed by the Administrator upon the recommendation of the Chief Medical Director.

* * * * *

[(b) Except as provided in subsection (c) of this section—

[(1) any appointment under this section shall be for a period of four years, with reappointment permissible for successive like periods,

[(2) any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years, and

[(3) any person so appointed or reappointed or whose appointment or reappointment, is extended shall be subject to removal by the Administrator for cause.]

(b)(1) Any appointment under subsection (a) of this section shall be for a period of four years, with reappointment permissible for successive four-year periods. Any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years. Any person appointed or reappointed, designated, or redesignated pursuant to this section, including subsection (c) of this section, or whose appointment or reappointment, designation or redesignation is extended shall be subject to removal for cause in the same manner and under procedures similar to those set forth in section 4110 of this title. The members of the disciplinary boards in such cases may be any persons appointed pursuant to this subsection.

CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

* * * * *

Subchapter I—Organization; General

* * * * *

§ 4103. Office of the Chief Medical Director

(a) The Office of the Chief Medical Director shall consist of the following—

(1) * * *

* * * * *

[(3) The Associate Deputy Chief Medical Director, who shall be an assistant to the Chief Medical Director and the Deputy Chief Medical Director, and who shall be a qualified doctor of medicine, appointed by the Administrator upon the recommendation of the Chief Medical Director.]

(3) Two Associate Deputy Chief Medical Directors, who shall be assistants to the Chief Medical Director and the Deputy Chief Medical Director, appointed by the Administrator upon the recommendation of the Chief Medical Director.

* * * * *

[(b) Except as provided in subsection (c) of this section—

[(1) any appointment under this section shall be for a period of four years, with reappointment permissible for successive like periods,

[(2) any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years, and

[(3) any person so appointed or reappointed or whose appointment or reappointment, is extended shall be subject to removal by the Administrator for cause.]

(b)(1) Any appointment under subsection (a) of this section shall be for a period of four years, with reappointment permissible for successive four-year periods. Any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years. Any person appointed or reappointed, designated, or redesignated pursuant to this section, including subsection (c) of this section, or whose appointment or reappointment, designation or redesignation is extended shall be subject to removal for cause in the same manner and under procedures similar to those set forth in section 4110 of this title. The members of the disciplinary boards in such cases may be any persons appointed pursuant to this subsection.

(2) Any person who relinquished an appointment made pursuant to section 4104(1) of this title in order to accept an appointment under this section and whose appointment, reappointment, or extension of appointment or reappointment under this section is terminated shall be entitled, upon such termination, to reemployment under section 4104(1) of this title.

* * * * *

§ 4104. Additional appointments

There shall be appointed by the Administrator additional personnel as the Administrator may find necessary for the medical care of veterans, as follows:

(1) Physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries;

(2) **[Pharmacists, psychologists]** *Psychologists* (other than those described in paragraph (3)), occupational therapists, dietitians, and other scientific and professional personnel, such as microbiologists, chemists, biostatisticians, and medical and dental technologists; and

(3) **[Clinical]** *Pharmacists, clinical* or counseling psychologists who hold diplomas as diplomates in psychology from an accrediting authority approved by the Administrator, certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses.

* * * * *

§ 4105. Qualifications of appointees

(a) Any person to be eligible for appointment to the following positions in the Department of Medicine and Surgery must have the application qualifications.

(1) Physician—

* * * * *

(9) Physician assistant, expanded-function dental auxiliary, certified or registered respiratory therapists, licensed physical therapists, licensed practical or vocational nurse, occupational therapist, dietitian, microbiologist, chemist, biostatistician, medical technologist, dental technologist, *pharmacist*, or other position—

have such medical dental, scientific, or technical qualifications as the Administrator shall prescribe.

* * * * *

§ 4106. Period of appointments; promotions

(a) * * *

[(b) Such appointments as described in subsection (a) of this section shall be for a probationary period of two years and the record of each person serving under such appointment in the Medical, Dental, and Nursing Services shall be reviewed from time to time by a board, appointed in accordance with regulations of the Administrator, and if said board shall find such person not fully qualified and satisfactory such person shall be separated from the service.]

(b) The first two years of employment of a person appointed under section 4104(1) of this title shall be a probationary period. The record of performance of any such employee may be reviewed at any time during that period by a board appointed under regulations prescribed by the Administrator. Procedures governing the review of employee performance during the probationary period shall be established in regulations prescribed by the Administrator. The board shall recommend to the Chief Medical Director action consistent with the ability of the employee, as determined by the board, to perform efficiently. The Chief Medical Director may accept, reject, or modify any recommendation of the board. If the Chief Medical Director takes action not recommended by the board, a statement of the reasons for such action shall be made part of the record.

* * * * *

§ 4107. Grades and pay scales.

(a) The annual rates or ranges of rates of basic pay for positions provided in section 4103 of this title shall be as follows:

[SECTION 4103 SCHEDULE

[Chief Medical Director, \$68,909

[Deputy Chief Medical Director, \$66,104.

[Associate Deputy Chief Medical Director, \$65,315.

[Assistant Chief Medical Director, \$61,449.

[Medical Director, \$52,429 minimum to \$59,421 maximum.

【Director of Nursing Service, \$52,429 minimum to \$59,421 maximum.

【Director of Podiatric Service, \$42,756 minimum to \$56,692 maximum.

【Director of Chaplain Service, \$44,756 minimum to \$56,692 maximum.

【Director of Pharmacy Service, \$44,756 minimum to \$56,692 maximum.

【Director of Dietetic Service, \$44,756 minimum to \$56,692 maximum.

【Director of Optometric Service, \$44,756 minimum to \$56,692 maximum.】

SECTION 4103 SCHEDULE

Chief Medical Director, \$97,206.

Deputy Chief Medical Director, \$93,248.

Associate Deputy Chief Medical Director, \$89,314.

Assistant Chief Medical Director, \$86,682.

Medical Director, \$73,958 minimum to \$83,818 maximum.

Director, \$63,135 minimum to \$79,975 maximum.

(b)(1) The grades and annual ranges of rates of basic pay for positions provided for in paragraph (1) of section 4104 of this title shall be as follows:

【PHYSICIAN AND DENTIST SCHEDULE

【Director grade, \$44,756 minimum to \$56,692 maximum.

【Executive grade, \$41,327 minimum to \$53,729 maximum.

【Chief grade, \$38,160 minimum to \$49,608 maximum.

【Senior grade, \$32,442 minimum to \$42,171 maximum.

【Intermediate grade, \$27,453 minimum to \$35,688 maximum.

【Full grade, \$23,087 minimum to \$30,017 maximum.

【Associate grade, \$19,263 minimum to \$25,041 maximum.

【NURSE SCHEDULE

【Director grade, \$38,160 minimum to \$49,608 maximum.

【Assistant Director grade, \$32,442 minimum to \$42,171 maximum.

【Chief grade, \$27,453 minimum to \$35,688 maximum.

【Senior grade, \$23,087 minimum to \$30,017 maximum.

【Intermediate grade, \$19,263 minimum to \$25,041 maximum.

【Full grade, \$15,920 minimum to \$20,699 maximum.

【Associate grade, \$13,700 minimum to \$17,813 maximum.

【Junior grade, \$11,712 minimum to \$15,222 maximum.

【CLINICAL PODIATRIST AND OPTOMETRIST SCHEDULE

【Chief grade, \$38,160 minimum to \$49,608 maximum.

【Senior grade, \$32,442 minimum to \$42,171 maximum.

【Intermediate grade, \$27,453 minimum to \$35,688 maximum.

【Full grade, \$23,087 minimum to \$30,017 maximum.

【Associate grade, \$19,263 minimum to \$25,041 maximum.】

PHYSICIAN AND DENTIST SCHEDULE

Director grade, \$63,135 minimum to \$79,975 maximum.

Executive grade, \$58,297 minimum to \$75,784 maximum.
Chief grade, \$53,830 minimum to \$69,976 maximum.
Senior grade, \$45,763 minimum to \$59,488 maximum.
Intermediate grade, \$38,727 minimum to \$50,346 maximum.
Full grade, \$32,567 minimum to \$42,341 maximum.
Associate grade, \$27,172 minimum to \$35,326 maximum.

NURSE SCHEDULE

Director grade, \$53,830 minimum to \$69,976 maximum.
Associate Director grade, \$45,763 minimum to \$59,488 maximum.
Chief grade, \$38,727 minimum to \$50,346 maximum.
Senior grade, \$32,567 minimum to \$42,341 maximum.
Intermediate grade, \$27,172 minimum to \$35,326 maximum.
Full grade, \$22,458 minimum to \$29,199 maximum.
Associate grade, \$19,326 minimum to \$25,122 maximum.
Junior grade, \$16,521, minimum to \$21,480 maximum.

CLINICAL PODIATRIST AND OPTOMETRIST SCHEDULE

Chief grade, \$53,830 minimum to \$69,976 maximum.
Senior grade, \$45,763 minimum to \$59,488 maximum.
Intermediate grade, \$38,727 minimum to \$50,346 maximum.
Full grade, \$32,567 minimum to \$42,341 maximum.
Associate grade, \$27,172 minimum to \$35,326 maximum.

* * * * *

(c)(1) * * *

* * * * *

(3) Notwithstanding the provisions of section 410(e) of this title, any person to whom paragraph (1) of this subsection applies *and any person appointed under section 4103 of this title who is not eligible for special pay under section 4118 of this title* shall be deemed to be a career appointee for the purposes of sections 4507 and 5384 of title 5.

* * * * *

(e)(1) * * *

* * * * *

(3) A nurse performing service on a tour of duty, any part of which is within the period commencing at midnight **[Saturday]** *Friday* and ending at midnight Sunday, shall receive additional pay for each hour of service on such tour at a rate equal to 25 percent of such nurse's hourly rate of basic pay.

* * * * *

(f) Physician assistants and expanded-function dental auxiliaries shall be compensated by use of Nurse Schedule grade titles and related pay ranges and shall be entitled to additional pay on the same basis as provided for nurses in subsection (e) of this section. Notwithstanding any other provision of law, when the Administrator determines it to be necessary in order to obtain or retain the services of *registered pharmacists, certified or registered respiratory therapists, licensed physical therapists, or licensed practical or vocational nurses*, the Administrator may, on a nationwide, local,

or other geographic basis, pay persons employed in such positions additional pay on the same basis as provided for nurses in subsection (e) of this section. The Administrator shall prescribe by regulation standards for compensation and payment under this subsection.

* * * * *

(j) Notwithstanding any other provision of law, a health care employee, or employee providing services incident to health care, who is employed pursuant to title 5 or paragraph (2) or (3) of section 4104 of this title and who is officially scheduled to be on call during a period other than the employee's regular hours of duty or on a holiday designated by law or Executive order shall be paid for each hour of such on-call duty (other than time the employee was actually at work) at a rate equal to 10 percent of the hourly overtime rate for services in excess of the employee's regularly scheduled duty.

* * * * *

§ 4110. Disciplinary boards

[(a) The Chief Medical Director, under regulations prescribed by the Administrator shall from time to time appoint boards to be known as disciplinary boards, each such board to consist of not less than three nor more than five employees, senior in grade, of the Department of Medicine and Surgery, to determine, upon notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed in a position provided in paragraph (1) of section 4104 of this title. The majority of employees on a disciplinary board shall be employed in the same category of position as the employee who is the subject of the charges.]

(a)(1) The Administrator may appoint boards to be known as disciplinary boards. Each such board shall consist of not less than three nor more than five employees of the Department of Medicine and Surgery who are senior in grade.

(2) A disciplinary board shall determine charges in a covered disciplinary action (as defined in paragraph (6) of this subsection) brought against a person employed in a position provided in section 4104(1) of this title. A determination by a board shall be made after notice and opportunity for a fair hearing.

(3) The majority of the members of a disciplinary board shall be employees in the same category of position as the employee who is the subject of the charges.

(4) The appointment of disciplinary boards shall be made under regulations prescribed by the Administrator.

(5) *In the case of charges arising from performance or conduct of duties during a person's tenure with the Veterans' Administration that are brought against a person employed in a position provided in section 4104(1) of this title in a case that is not a covered disciplinary action, the matter shall be determined in accordance with procedures to be prescribed by the Administrator.*

(6) *For the purposes of this subsection, the term 'covered disciplinary action' means a disciplinary action—*

(A) arising from performance or conduct of duties during a person's tenure with the Veterans' Administration; and

(B) *proposing that the person involved be—*

(i) removed,

(ii) suspended for more than 14 days, or

(iii) given a demotion involving the loss of grade or pay.

* * * * *

(c) The **Chief Medical Director** Administrator may designate or appoint one or more investigators, to assist each disciplinary board in the collection and presentation of evidence. Any person answering to charges before a disciplinary board may be represented by counsel chosen by such person.

(d) A disciplinary board, when in its judgment charges are sustained, shall recommend to the Administrator **suitable disciplinary action, within limitations prescribed by the Administrator, which shall include reprimand, suspension without pay, reduction in grade, and discharge from the Department of Medicine and Surgery of such person.** *that the proposed disciplinary action by sustained or modified in accordance with limitations prescribed by the Administrator.* The Administrator shall either approve the recommendation of the board, approve such recommendation with modification or exception, approve such recommendation and suspend further action at the time, or disapprove such recommendation. The Administrator shall cause to be executed such action as the Administrator approves. The decision of the Administrator shall be final.

(e) The Administrator, within such limitations as the Administrator may prescribe may delegate to the Chief Medical Director the authority vested in the Administrator by subsections (b) and (d) of this section to (1) appoint the chairman and secretary of a disciplinary board, such official to have the power prescribed by this section, and (2) receive and act upon the recommendations of such a board. Any person against whom disciplinary action is taken under authority delegated pursuant to this subsection shall have the right to appeal such action to the Administrator, but in the absence of such an appeal the decision of the Chief Medical Director shall have the same force and effect as a decision of the Administrator.

(e) *Any person with respect to whom a decision is made to take disciplinary action under authority delegated under subsection (d) of this section shall have the right to appeal such decision to the Administrator. In the absence of such an appeal such decision shall have the same force and effect as a decision of the Administrator.*

* * * * *

§ 4114. Temporary full-time, part-time, and without compensation appointments; residences or internships

(a) * * *

* * * * *

(d) The Chief Medical Director may waive for the purpose of appointments under this section the requirements of section 4105(a) of this title that the licensure of a physician, dentist, podiatrist, psychologist, or optometrist, or the registration of a nurse must be in a "State", if—

[(1) in the case of a physician, dentist, podiatrist, psychologist, or optometrist, the person is to be used on a research or an academic post or where there is no direct responsibility for the care of patients; or

[(2) in any case, where the person is to serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.]

(d) *The Chief Medical Director may waive for the purpose of an appointment under this section the requirement of section 4105(a) of this title that the licensure or registration, as appropriate, of a physician, dentist, podiatrist, psychologist, optometrists, registered nurse, practical or vocational nurse, or physical therapist be in a State if the person to be appointed—*

(1) is to be employed in a research post or an academic post or where there is otherwise no direct responsibility for the care of patients; or

(2) is to serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.

* * * * *

[(e) The Administrator, within such limitations as the Administrator may prescribe may delegate to the Chief Medical Director the authority vested in the Administrator by subsections (b) and (d) of this section to (1) appoint the chairman and secretary of a disciplinary board, such official to have the power prescribed by this section, and (2) receive and act upon the recommendations of such a board. Any person against whom disciplinary action is taken under authority delegated pursuant to this subsection shall have the right to appeal such action to the Administrator, but in the absence of such an appeal the decision of the Chief Medical Director shall have the same force and effect as a decision of the Administrator.]

(e) Any person with respect to whom a decision is made to take disciplinary action under authority delegated under subsection (d) of this section shall have the right to appeal such decision to the Administrator. In the absence of such an appeal such decision shall have the same force and effect as a decision of the Administrator.

* * * * *

§ 4114. Temporary full-time, part-time, and without compensation appointments; residences or internships

(a) * * *

* * * * *

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[(1) in the case of a physician, dentist, podiatrist, psychologist, or optometrist, the person is to be used on a research or an academic post or where there is no direct responsibility for the care of patients; or

[(2) in any case, where the person is to serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.]

(d) *The Chief Medical Director may waive for the pupose of an appointment under this section the requirement of section 4105(a) of this title that the licensure or registration, as appropriate, of a physician, dentist, podiatrist, psychologist, optometrists, registered nurse, practical or vocational nurse, or physical therapist be in a State if the person to be appointed—*

(1) is to be employed in a research post or an academic post or where there is otherwise no direct responsibility for the care of patients; or

(2) is to serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.

* * * * *

§ 4116. Defense of certain malpractice and negligence suits

(a) * * *

* * * * *

(f) *For purposes of this section, section 2680(h) of title 28 shall not apply to any claim arising out of a negligent or wrongful act or omission of any person described in subsection (a) of this section in furnishing medical care or treatment (including the conduct of clinical studies and investigations) while in the exercise of such person's duties in or for the Department of Medicine and Surgery.*

* * * * *

Subchapter IV—Veterans' Administration Health Professional Scholarship Program

* * * * *

§ 4142. Eligibility; application; written contract

(a) To be eligible to participate in the Scholarship Program, an individual must—

(1) be accepted for enrollment, or be enrolled, as a student (A) in an accredited (as determined by the Administrator) educational institution in a State, and (B) in a course of training offered by such institution and approved by the Administrator, leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing [of a course of training to become a physician assistant or expanded-function dental auxiliary;] or otherwise leading to qualification for employment in a position described in section 4104 of this title;

* * * * *

§ 4144. Breach of contract; liability; waiver

(a) * * *

(b) A participant in the Scholarship Program who—

(1) * * *

* * * * *

(4) fails to [become licensed to practice medicine, osteopathy, dentistry, podiatry, or optometry in a State, fails to become registered as a graduate nurse in a State, or fails to meet any applicable licensure requirement in the case of a physician assistant or expanded-function dental auxiliary, during] *meet any applicable licensure or registration requirement within a period of time determined under regulations prescribed by the Administrator, or*

* * * * *

§ 4116. Defense of certain malpractice and negligence suits

(a) * * *

* * * * *

(f) *For purposes of this section, section 2680(h) of title 28 shall not apply to any claim arising out of a negligent or wrongful act or omission of any person described in subsection (a) of this section in furnishing medical care or treatment (including the conduct of clinical studies and investigations) while in the exercise of such person's duties in or for the Department of Medicine and Surgery.*

* * * * *

Subchapter IV—Veterans' Administration Health Professional Scholarship Program

* * * * *

§ 4142. Eligibility; application; written contract

(a) To be eligible to participate in the Scholarship Program, an individual must—

(1) be accepted for enrollment, or be enrolled, as a student (A) in an accredited (as determined by the Administrator) educational institution in a State, and (B) in a course of training offered by such institution and approved by the Administrator, leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing [of a course of training to become a physician assistant or expanded-function dental auxiliary;] *or otherwise leading to qualification for employment in a position described in section 4104 of this title;*

* * * * *

§ 4144. Breach of contract; liability; waiver

(a) * * *

(b) A participant in the Scholarship Program who—

(1) * * *

* * * * *

(4) fails to [become licensed to practice medicine, osteopathy, dentistry, podiatry, or optometry in a State, fails to become registered as a graduate nurse in a State, or fails to meet any applicable licensure requirement in the case of a

physician assistant or expanded-function dental auxiliary, during] meet any applicable licensure or registration requirement within a period of time determined under regulations prescribed by the Administrator, or

* * * * *

CHAPTER 75—VETERANS' CANTEEN SERVICE

Sec.

4201. Purpose of Veterans' Canteen Service.

* * * * *

4209. Exemption from personnel ceilings.

* * * * *

§ 4205. Revolving fund

The revolving fund shall be deposited in a checking account with the Treasury of the United States. Such amounts thereof as the Administrator may determine to be necessary to establish and maintain operating accounts for the various canteens may be deposited in checking accounts or other interest-bearing accounts in other depositories selected by the Administrator.

§ 4206. Budget of Service

The Service shall prepare annually and submit a budget program as provided for wholly owned Government corporations by chapter 91 of title 31, which shall contain an estimate of the needs of the Service for the ensuing fiscal year including an estimate of the amount required to restore any impairment of the revolving fund resulting from operations of the current fiscal year. [Any balance in the revolving fund at the close of the fiscal year in excess of the estimated requirements for the ensuing fiscal year shall be covered into the Treasury as miscellaneous receipts.]

* * * * *

§ 4209. Exemption from personnel ceilings

Persons who are employed by the service and compensated from the revolving fund established by section 4204 of this title may not be considered to be employees of the Veterans' Administration for the purposes of any personnel ceiling which may otherwise be applied to employees of the Veterans' Administration by the President.

* * * * *

PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

* * * * *

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES: PROCUREMENT AND SUPPLY

* * * * *

Subchapter I—Acquisition and Operation of Medical Facilities

* * * * *

§ 5010. Operation of medical facilities

(a)(1) * * *

* * * * *

(6)(A) *Temporary research personnel of the Veterans' Administration shall be excluded from any ceiling on full-time equivalent employees of the Veterans' Administration or any other personnel ceiling otherwise applicable to employees of the Veterans' Administration.*

(B) *For purposes of subparagraph (A) of this paragraph, the term "temporary research personnel" means personnel who are employed by the Veterans' Administration in other than a career appointment for work on a research activity and who are not paid by the Veterans' Administration or are paid from funds appropriated to the Veterans' Administration to support such activity.*

* * * * *

Subchapter II—Procurement and Supply

* * * * *

§5022. Authority to procure and dispose of property and to negotiate for common services

(a)(1) * * *

[(2)(A) Before entering into a transaction described in subparagraph (B) of this paragraph with respect to any real property owned by the United States and administered by the Veterans Administrator which has an estimated value in excess of \$50,000, the Administrator shall submit a report of the facts concerning the proposed transaction to the Committees on Veterans' Affairs of the Senate and House of Representatives, and such transaction may not then be entered into until after the expiration of 180 days from the date upon which the report is submitted.]

[(B) Subparagraph (A) of this paragraph applies to (i) any transfer of an interest in real property to another Federal agency or to a State (or any political subdivision of a State), and (ii) any report to a Federal disposal agency of excess real property.]

[(C) A statement in an instrument of conveyance, including a lease, that the requirements of this paragraph have been met, or that the conveyance is not subject to this paragraph, is conclusive for the purpose of all matters pertaining to the ownership of any right or interest in the property conveyed by such instrument.]

(2) The Administrator may not transfer any interest in real property owned by the United States and administered by the Veterans' Administration which has an estimated value in excess of \$50,000 to another Federal agency or to a State (or any political subdivision of a State) unless such transfer is specifically authorized by law after the date of the enactment of the Veterans' Administration Health-Care Amendments of 1987.

(3) Amounts realized from the sale of any interest in real property described in paragraph (2) shall be deposited in the fund established under section 5009 of this title.

* * * * *

SECTION 201(b) OF THE VETERANS' HEALTH CARE AMENDMENTS OF 1979

TITLE II—CONTRACT-CARE PROGRAMS

DEFINITION OF "VETERANS' ADMINISTRATION FACILITIES"

SEC. 201. (a) * * *

[(b) Not later than February 1, 1980, and annually thereafter, the Chief Medical Director of the Veterans' Administration shall submit to the appropriate committees of the Congress, through the Administrator of Veterans' Affairs, a full report on the implementation of section 601(4)(C)(v) of title 38, United States Code, and the amendments made by this section, and on the numbers of veterans provided contract treatment (and the average cost and duration thereof) in each State (as defined in section 101(20) of title 38, United States Code) in the categories described in the following provisions of such title: sections 601(4)(C), 610(a), 612(a), 612(f)(1)(A), 612(f)(1)(B), 612(f)(2), 612(g), 612A (as added by section 103(a)(1) of this Act), the third sentence of section 612(f) (as added by section 102(b)(2) of this Act), and section 620A (as added by section 104(a) of this Act).]

○